LIST OF ATTACHMENTS

ATTACHMENT A

Examples of Effective Interventions for MSM

SPG Recommendations Regarding MSM

EXAMPLES OF EFFECTIVE MSM INTERVENTIONS

The ***Effective Intervention Committee*** was presented the task of providing information to the full State Planning Group concerning interventions with scientifically proven effectiveness. After reviewing numerous articles discussing interventions to reach the MSM population, the committee recommends the listed interventions as possibilities to reach your MSM population. Taking into consideration that **your** MSM population fits into the intervention. The list presented by the committee is NOT all-inclusive. It is intended to give you an idea of the interventions that have been successful in reaching MSM populations in different areas of the country. If your MSM population does not fit exactly into one of the interventions, we suggest you adapt the intervention to meet your needs or select an intervention type listed to assist with your prevention efforts.

INTERVENTION TYPE	BEHAVIORAL RISK	ARTICLE	DESCRIPTION	CORE ELEMENTS
HEALTH EDUCATION RISK REDUCTION				
Community Level Intervention	Young MSM engaging in unprotected anal intercourse	***The Mpowerment Project: A Community-level HIV Prevention Intervention for Young Gay Men*** Kegles, S.M., Hayes, R.B., & Coates, T.J. (1996) *American Journal of Public Health*, 86(8), 1129 - 1136	This intervention is based on peer influence and diffusion of innovation theories. The goal is to reduce the number of unprotected anal intercourse by those who participants in the intervention. This is a multi component intervention that included outreach, small groups, and a media campaign.	➢ Peer led ➢ Board of elders ➢ Outreach ➢ Media campaign ➢ Safe environment used as a meeting place ➢ Small groups
Community Level Intervention	MSM and heterosexually identified MSM engaging in unprotected anal intercourse.	***Community-Level HIV Intervention in 5 cities: Final Outcome Data From the CDC AIDS Community Demonstration Projects*** The CDC AIDS Community Demonstration Projects Research Group (1999) *American Journal of Public Health*, 89, 336-345	*Community Promise* (Peers Reaching Out and Modeling Intervention Strategies) is based on the article mentioned. There are three major components to this intervention: role-model stories, peer advocates, and prevention materials. Using several theories and models, the goal of the intervention is to increase consistent use for anal and vaginal intercourse with main and other partners, and or increase consistent use of bleach for cleaning needles.	➢ Assessing community needs ➢ Recruiting community peer advocates ➢ Creating role model stories from prioritized population community members ➢ Distribution of stories and risk reduction supplies

INTERVENTION TYPE	BEHAVIORAL RISK	ARTICLE	DESCRIPTION	CORE ELEMENTS
Group Level Intervention	MSM (Hispanic men) engaging in unprotected anal intercourse	***Hermonas de Luna y Sol: The Building of an Empowered Community*** Mario Huerts (program Coordinator). *First Annual CAPS Conference*, April 2001.	There were three interrelated activities involved in this program: bar outreach and recruitment, group sessions, and an individual session. Sessions addressed main issues Latino gay men face, exploring strategies for survival, sharing the role sex has in their lives, emotional challenges, exploring AIDS impact on their lives, and exploring diversity.	➢ Six week discussion workshop ➢ Weekly discussion/support group for graduates of main program ➢ Individual, Client centered risk-reduction counseling ➢ Ethnically, culturally, and linguistically appropriate
Group Level Intervention	MSM engaging in risky behavior	***A skills-Training Group Intervention Model to assist Persons in Reducing Risk Behaviors for HIV Infection*** Jeffrey A. Kelley, PhD, Janet S. St. Lawrence, PhD, et al. *AIDS Education and Prevention*, 2(1) 24-53 1990	This intervention was conducted in seven 60-90 minute sessions. Sessions familiarized participants with HIV and AIDS transmission, self-management training, group problem solving, assertiveness traini9ng, and pride, efficacy, and support issues. The goal of the intervention was to change the risky behavior of the MIS in the community who participated in the intervention.	➢ In-depth baseline and follow-up assessment ➢ Seven group sessions consisting of risk education, self-management, skills building, and assertiveness training ➢ Three month follow-up booster session
Group Level Intervention	MSM engaging in unprotected intercourse	***AIDS Prevention in Homosexual and Bisexual men: Results of a Randomized Trial Evaluating Two Risk Reduction Interventions*** Valdiserri, R.O., Lyter, D.W., Leviton, L.C., Callahan, C.M., et al (1989) AIDS, 3(1), 21-26	This intervention consists of lecture and skills training delivered in two small group. Session 1 consists of a 60-90 minute lecture reviewing HIV transmission, outlook of HIV infection, risky practices, importance of risk reduction and practicing sex safely, condom use, and interpreting HIV test. Session two was a 140-minute skills-training session (role play, group discussion, psychodrama, etc.). There is also a 6 month and 1 year post intervention follow-up interview.	➢ Properly trained health professional ➢ Small group lecture ➢ Skills training
Group Level Intervention	HIV Positive	***Effectiveness of an Intervention to Reduce HIV Transmission Risk in HIV Positive People*** Seth C. Kalichman, PhD., et al.	The Social Cognitive Theory was the foundation for this behavioral change intervention. The goal of the intervention was to assist participants develop coping skills; enhance effective	➢ Five sessions ❖ Self efficacy ❖ Transmission risk ➢ Gender specific presentations (males and

INTERVENTION TYPE	BEHAVIORAL RISK	ARTICLE	DESCRIPTION	CORE ELEMENTS
		American Journal of Preventive Medicine 2001:21(2) 84-92	decision making around disclosure; and the development and maintenance of safer sexual practices. The five 120 minutes sessions were delivered at the rate of two per week.	females separated) ➢ Time series measurement (immediate post intervention, 3 months, and 6 months)
Group Level Intervention	HIV Positive	***Cognitive Theory of Substance Abuse*** Beck, A., Wright, F., Newman, C., and Liese, B.S. (1993) New York: Guilford Press ***The Neurobehavioral Treatment Manual*** Rawson, R., Obert, J., McCann, M., & Scheffey, (1991) Beverly Hills, CA: Matrix Center	*Positive Images* workshops are conducted once a week for three consecutive weeks. Each weekly session lasts for approximately 2 hours. The purposes of the workshops are to increase the quality of life and reduce HIV transmission among HIV positive persons. The three workshops will address issues regarding self-understanding, living with HIV, and staying healthy. This topic: "***Prevention with HIV Positive People. What is It? How to do it!***" was discussed at the United States Conference on AIDS Institute, September 19, 2002	➢ Three 2 hour sessions ➢ Adherence to the curriculum ➢ Non threatening environment ➢ Participant participation
Prevention Case Management	HIV+ MSM and Their Partners	***HIV Prevention Case Management Guidance and Literature Review and Current Practice.*** *US Department of Health and Human Services. Public Health Service* (1997)	The guidance defines and outlines developing, planning, and implementing prevention case management. PCM may be more costly than other HIV prevention activities, but cost effective because in emphasizes serving persons with particular difficulties changing behavior.	➢ Client recruitment and engagement ➢ Screen and assessment ➢ Development of a client centered prevention plan ➢ HIV risk reduction counseling ➢ Coordinate services ➢ Monitor clients needs and progress ➢ Discharge

INTERVENTION TYPE	BEHAVIORAL RISK	ARTICLE	DESCRIPTION	CORE ELEMENTS
HEALTH COMMUNICATION / PUBLIC INFORMATION				
Social Marketing	HIV+ Bisexual & Gay men and transgender	***Positive Images: HIV Stops With Me*** AIDS Project of Los Angeles 2002	The campaign consisted of a website, newspaper ad, post cards, and a TV commercial aired during prime time. All images/models were HIV+. They talked about their sexuality; how they found out they were HIV positive, and how this has affected their lives. There is other information about each person, including personal type of information. Many of the population presented were people of color.	➢ Realistic HIV + persons presenting true stories
COUNSELING, TESTING AND REFEREAL / PARTNER COUNSELING AND REFERRAL SERVICE				
Counseling, Testing, and Referral		***Revised Guidelines for HIV Counseling, Testing, and Referral*** Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report Recommendations and Reposts November 9, 2001/Vol50/No. RR-19	This is the fifth revision of guidance for HIV Counseling and testing that originally was distributed in 1986. The guidance outlines the goals of HIV Counseling, Testing, and Referral as: ensuring HIV infected persons and persons at increased risk have access to HIV testing, receive high quality HIV prevention counseling, have assess to appropriate services (medical, prevention, and psychosocial support services), and promote early knowledge of HIV status. Client centered and focused interactive counseling is more effective.	➢ Keep sessions focused on HIV risk reduction. ➢ Include personalized in-depth risk assessment ➢ Acknowledge and provide support for steps already made ➢ Clarify critical misconceptions. ➢ Negotiate concrete, achievable behavior change steps to reduce HIV risk ➢ Seek Flexibility in prevention approach ➢ Provide skill-building opportunities ➢ Use explicit language when providing test results

Recommendations, Questions and Considerations to State, Regional and Local Planning Groups, Funding Agencies, and Prevention Program Providers in Washington State

The following recommendations were developed by the Washington State Planning Group (SPG) as a result of a discussion of the current risk behavior data on men who have sex with men (MSM) and the risk of HIV and AIDS in the state. The SPG makes these recommendations recognizing regional differences in the epidemiology and incidence and prevalence of HIV and AIDS, and offers them as guidance for planning, funding, and implementation efforts across the state.

1. State, Regional and Local Planning Groups, Funding Agencies, and Prevention Program Providers revisit the current reality of HIV/AIDS to MSM and MSM/IDU

We recommend planning groups, funders and providers consider the ramifications and health consequences of HIV/AIDS are fully reflected in the messages in their plans and services including:

- Problems with anti-viral drug resistance associated with current treatment modalities. The lack of cure or a vaccine in the immediate future, and the limitations and side effects of current medications
- The basics of transmission, including the relative risks associated with the varieties of sexual exposure
- The importance of knowing one's HIV status

In addition we recommend planners, funders and providers involved in the development of plans and services consider the following issues:

- Young MSM and their particular needs
- The dual prevention needs of MSM/IDU
- Persons with HIV infection who are subsequently treated for a sexually transmitted disease
- Venues including baths, rest stops, the internet and other venues that facilitate casual and/or anonymous unprotected sex
- Methamphetamine use and its role in the sexual transmission of HIV
- The contribution of other drugs and alcohol in addressing MSM risk taking
- The effectiveness and integrity of interventions currently in use
- Staff training and skill building, including standards to assure accessibility to and acceptability by the target populations
- The prevention needs of HIV positive individuals who are in care
- The prevention needs of those co-infected with HIV and Hepatitis C (HCV)

2. The review process of the Regional Plans and Services by the State Planning Group will include a review of these recommendations in those plans and the progress of addressing these issues.

3. After considering the current epidemiology of the co-infection of HIV and STDs in men who have sex with men (MSM) in Washington State, the State Planning Group (SPG) makes the following recommendation:

- The State Planning Group is seriously concerned about the level of risk-taking by MSM for both HIV and STDs that continues to take place in the Seattle 'baths' and clubs. Risk factors include the various drugs and alcohol that enhance the level of unprotected sex with multiple anonymous partners in the bath environment. The SPG recommends that local and state public health along with other authorities work together to conduct a needs assessment, enhance interventions and explore other options to reduce the current prevalence of sexual and drug risk behaviors within the baths.

ATTACHMENT B

Examples of Effective Interventions for IDU

SPG Recommendations Regarding IDU

EXAMPLES OF EFFECTIVE IDU INTERVENTIONS

The ***Effective Intervention Committee*** was presented the task of providing information to the full State Planning Group concerning interventions with scientifically proven effectiveness. After reviewing numerous articles discussing interventions to reach the IDU population, the committee recommends the listed interventions as possibilities to reach your IDU population. Taking into consideration that **your** IDU population fits into the intervention. The list presented by the committee is NOT all-inclusive. It is intended to give you an idea of the interventions that have been successful in reaching IDU populations in different areas of the country. If your IDU population does not fit exactly into one of the interventions, we suggest you adapt the intervention to meet your needs or select an intervention type listed to assist with your prevention efforts.

*Studies demonstrate syringe exchange programs reduce the sharing of syringes, are effective in preventing HIV and other Bloodborne diseases, and are cost effective. Federal dollars are **NOT** permitted to support this intervention type. It is recommended those communities with other funding source and limited political barriers, should establish a syringe exchange.*

INTERVENTION TYPE	BEHAVIORAL RISK	ARTICLE	DESCRIPTION	CORE ELEMENTS
HEALTH EDUCATION RISK REDUCTION				
Community Level Intervention	IDUs sharing equipment or engaging in sexual intercourse	***Increasing the Use of Bleach and Condoms Among Injecting Drug Users in Denver: Outcomes of a Targeted Community Level Intervention HIV Prevention Program*** Cornelis A. Rielmeifer, et al. AIDS 1996 10:291-298	This program called *Project REACH* (Risk Education Aimed at Community Health), had two goals. The intervention sought to increase the use of bleach for needle cleaning and increase condoms use for vaginal intercourse with steady and occasional partners. The foundation for this intervention was the "Stages of Change Model", although other theories and models were integrated into the program as well. Small media materials containing role model stories were developed and delivered to those at risk.	➢ Development of media materials (brochures, pamphlets, flyers, and newsletters) ➢ Street and Community outreach contact one-on-one (delivering bleach kits and condoms) ➢ Trained Peer volunteers

INTERVENTION TYPE	BEHAVIORAL RISK	ARTICLE	DESCRIPTION	CORE ELEMENTS
Community Level Intervention	IDUs sharing needles and engaging in unprotected sex	***Community-Level HIV Intervention in 5 cities: Final Outcome Data From the CDC AIDS Community Demonstration Projects*** The CDC AIDS Community Demonstration Projects Research Group (1999) American Journal of Public Health, 89, 336-345	Community "Promise" (Peers Reaching Out and Modeling Intervention Strategies) is based on the article mentioned. There are three major components to this intervention: role-model stories, peer advocates, and prevention materials. Using several theories and models, the goal of the intervention is to increase consistent use of condoms for anal and vaginal intercourse with main and other partners, and or increase consistent use of bleach for cleaning needles.	➢ Assessing community needs ➢ Recruiting community peer advocates ➢ Creating role model stories from prioritized population community members ➢ Distribution of stories and risk reduction supplies
Group Level Intervention	HIV Positive	***Effectiveness of an Intervention to Reduce HIV Transmission Risk in HIV Positive People*** Seth C. Kalichman, PhD., et al. American Journal of Preventive Medicine 2001:21(2) 84-92	The Social Cognitive Theory was the foundation for this behavioral change intervention. The goal of the intervention was to assist participants develop coping skills; enhance effective decision making around disclosure; and to develop and maintain safer sexual practices. The five 120 minutes sessions were delivered at the rate of two per week.	➢ Five sessions ❖ Self efficacy ❖ Transmission risk ➢ Gender specific presentations (males and females separated) ➢ Time series measurement (immediate post intervention, 3 months, and 6 months)
Group Level Intervention	Incarcerated adolescent males with past history of multiple unprotected sex partners and/or illicit drug use	***Outcomes of Intensive AIDS Education for Male Adolescents Drug Users in Jail*** Stephen Magura, PhD, et al. Journal of Adolescent Health 1994; 15:457-463	This group oriented AIDS education program is based on the Problem Solving Theory. Small groups receive four twice-weekly sessions for one hour. The sessions addressed problem orientation, definition and formulation, generated alternate solutions, decision-making, and solution implementation.	➢ In depth base line interview with signed consent (great for evaluation purposes) ➢ Small group sessions using problem solving theory ➢ Follow set curriculum ➢ Racially/ethnically/situational peer educator.
Group Level Intervention	HIV Positive	***Cognitive Theory of Substance Abuse*** Beck, A., Wright, F., Newman, C., and Liese, B.S. (1993) New York: Guilford Press	*Positive Images* workshops are conducted once a week for three consecutive weeks. Each weekly session lasts for approximately 2 hours. The purposes of the workshops are to increase the quality of life and reduce	➢ Three 2 hour sessions ➢ Adherence to the curriculum ➢ Non threatening environment ➢ Participant participation

INTERVENTION TYPE	BEHAVIORAL RISK	ARTICLE	DESCRIPTION	CORE ELEMENTS
		The Neurobehavioral Treatment Manual Rawson, R., Obert, J., McCann, M., & Scheffey, (1991) Beverly Hills, CA: Matrix Center	HIV transmission among HIV positive persons. The three workshops will address issues regarding self-understanding, living with HIV, and staying healthy. This topic: "***Prevention with HIIV Positive People. What is It? How to do it!***" was discussed at the United States Conference on AIDS Institute, September 19, 2002	
Group Level Intervention	Inpatient drug detoxification and rehabilitation center.	***AIDS Education for Drug Abusers: Evaluation of Short-term Effectiveness*** McCuster, J., Stoddard, A.M., et al. (1992). American Journal of Public Health, 82 (4), 533-540	The intervention used Social Cognitive and Relapse Prevention theories as the foundation for the message delivery. The informational education intervention consisted of two 1-hour sessions, while the enhanced education intervention consisted of six 1-hour sessions and a 30-minute individual health education consultation.	➢ Small group sessions (six) ➢ 30 minute individual health education consultation
Individual Level Intervention	HIV Positive discordant couples	***Prevention of Heterosexual Transmission of Human Immunodeficency Virus Through Couple Counseling***" Padian NS, O'Brien TR et al (1993) Journal of Acquiredn Immuniodefiency Sydrome 6(9): 1043-8	This intervention seeks to promote and sustain behavior change among HIV positive persons and their HIV negative partner. Sessions lasted for approximately one hour and were conducted every 4 – 6 months, depending on the needs of the clients. Interviews were conducted separately and then as a couple. Telephonic consultations were available between visits if needed. Once enrolled, couples remained in the program as long as they deemed necessary to assist with sustaining behavior change.	➢ Individual interviews ➢ Joint interviews ➢ Structured sessions (role play, HIV transmission, contraception, conception) harm reduction.
Individual Level Intervention	Out of treatment drug users (crack users) women who inject, IDU/MSM,	***The NIDA Community Based Outreach Model***" The National Institute on Drug Abuse	This intervention featured community based outreach as a way to assess drug users risk and to elicit their commitment to HIV/AIDS risk	➢ Community-based outreach ➢ Role model outreach workers ➢ Two sessions of education and risk reduction (session 1

INTERVENTION TYPE	BEHAVIORAL RISK	ARTICLE	DESCRIPTION	CORE ELEMENTS
	and those who inject drugs and identify with sex trader behavior	(NIDA) September 2000	reduction, followed by two 20-30 sessions The health belief theory (perception of personal vulnerability), communication theory (credibly messages) and the principles of HIV Prevention for drug using populations were used in the delivery of this intervention. For this model, drug treatment is viewed as an important strategy.	– HIV, HBV HCV transmission and prevention. Session 2-review risk reduction information and support & reinforce behavior changes).
Needle Exchange	IDUs and non-injecting partners	***Impact of HIV Risk and Infection and the Role of Prevention Services*** Watters, J.K. (1996) Journal of Substance Abuse Treatment, 13(5), 375-385 ***Syringe and Needle Exchange as HIV/AIDS Prevention for Injection Drug Users*** Watters, J.K., Estilo, M.J., et al (1994) Journal of American Medical Association, 271(2), 115-120	The overall goal of *Point for Point* (available from Sociometrics) is to reduce the spread of HIV by reducing the prevalence of needle sharing. The program centers on harm reduction principles and tries to meet IDUs on their terms. Along with clean needles, the exchange personnel distribute material designed to reduce the risk of HIV/AIDS transmission and provide referrals to needed services (including counseling and testing). The other information provided is how to implement an exchange or enhance an exiting exchange.	➢ Trained volunteers (six hours classroom and six week apprenticeship) ➢ Consistent operation ➢ Full community support (including law enforcement) ➢ Operate in a respectful and nonjudgmental manner.
Prevention Case Management	HIV + IDUs and their partners	***HIV Prevention Case Management Guidance and Literature Review and Current Practice.*** US Department of Health and Human Services. Public Health Service (1997)	The guidance defines and outlines developing, planning, and implementing prevention case management. PCM may be more costly than other HIV prevention activities, but cost effective because in emphasizes serving persons with particular difficulties changing behavior.	➢ Client recruitment and engagement ➢ Screen and assessment ➢ Development of a client centered prevention plan ➢ HIV risk reduction counseling ➢ Coordinate services ➢ Monitor clients needs and progress ➢ Discharge
Street and Community Outreach	IDUs sharing syringe and/or unprotected	***Impact of a Longiotudinal Community HIV Intervention Targeting Injecting Drug Users" Stage of Change for***	This intervention used key elements from three theories and two models in the delivery of this intervention. The	➢ Role model stories ➢ Newsletter ➢ Outreach by trained peer

INTERVENTION TYPE	BEHAVIORAL RISK	ARTICLE	DESCRIPTION	CORE ELEMENTS
	intercourse	***Condom and Bleach Use***" Margaret Schneider Jammer, et al. American Journal of Health Promotion 1997:12(1): 15-24	goals were to deliver prevention messages, increase condom use, and move IDUs along the stages-of-change continuum for condom use and cleaning their works.	volunteers ➢ Repeat exposure to information
HEALTH COMMUNICATION / PUBLIC INFORMATION				
There were not any interventions reviewed covering these areas. However, the delivery of these interventions must be conducted in a manner so the MSM population you desire to reach knows without any question you are addressing them and providing information to address their needs.				
COUNSELING, COUNSELING, ANDF REFERRAL / PARTNEN COUNSELING AND REFERRAL SERVICE				
Counseling, Testing, and Referral		***Revised Guidelines for HIV Counseling, Testing, and Referral*** Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report Recommendations and Reposts November 9, 2001/Vol50/No. RR-19	This is the fifth revision of guidance for HIV Counseling and testing that originally was distributed in 1986. The guidance outlines the goals of HIV Counseling, Testing, and Referral as: ensuring HIV infected persons and persons at increased risk have access to HIV testing, receive high quality HIV prevention counseling, have assess to appropriate services (medical, prevention, and psychosocial support services), and promote early knowledge of HIV status. Client centered and focused interactive counseling is more effective.	➢ Keep sessions focused on HIV risk reduction. ➢ Include personalized in-depth risk assessment ➢ Acknowledge and provide support for steps made ➢ Clarify critical misconceptions. ➢ Negotiate concrete, achievable behavior change steps to reduce HIV risk ➢ Seek Flexibility in prevention approach ➢ Provide skill-building opportunities ➢ Use explicit language when providing test results
Partner Counseling and Referral Service	IDUs who test positive	***The Outreach Assisted Model of Partner Notification with IDU***" Levy JA, Fox SE (1998) Public Health Reports 113 (5-1): 160-9	This intervention consisted of two groups for those IDUs who test positive for HIV. The minimal group was strongly encouraged to inform their partners of possible exposure to HIV. The enhanced group was given a choice of informing their partner or have an outreach worker do the notification.	➢Community based testing ➢Knowledgeable peer outreach workers (former users) ➢Team approach (HIV counselor and a male-female team outreach workers) ➢Referrals

Recommendations from the State Planning Group regarding HIV prevention priorities for intravenous drug users (IDUs)

The State Planning Group developed a list of over twenty recommendations for reinforcing prevention in IDUs in Washington State before prioritizing that list down to six. Other considerations on the list addressed education, training, collaboration, representation and additional resources. That list included: increasing representation on local and county advisory boards that regulate or consider policies on substance abuse, mental health, housing and treatment issues; investigating of the differences in transmission in subpopulations of IDUs; increasing the affordability of drugs and medications; increasing the quality assurance aspects of all phases of substance abuse from training and outreach to treatment licensure; and finally increasing the awareness of service needs for IDUs and reducing the barriers to those needs.

The final list of recommendations includes:

- ✓ Regional planning groups should analyze the nature of injection drug use in their region (drugs of choice, race and class, MSM users, etc) and insure their interventions are adequate to respond to those populations that are at highest risk. Insure integrity to respond. Include women.

- ✓ Promote Cross training of Counseling & Testing and Chemical Dependency counselors in motivational interviewing, stages of change theory, harm reduction, substance abuse prevention, as in “The Bridging of the Gap” (examining the mechanics of injecting, standardization).

- ✓ That the Department of Health work with the Division of Alcohol and Substance Abuse to standardize the mandated education for chemical dependency clients. Encourage integration of harm reduction into classes.

- ✓ Intervention Plans should describe how syringe access programs, including needle exchange and pharmacy access, address sexual transmission of HIV.

- ✓ Include prevention, education and testing of HCV along with HIV for IDUs.

- ✓ Increase access and affordability of opiate replacement therapy (for example, include the pill form of buprenorphine on the medical formularies of the AIDS Prescription Drug Program).

ATTACHMENT C

Prioritized Populations Transition Table

Prioritized populations by behavioral risk category, then by HIV status or other subpopulation characteristic

Table 1 (from 2002-2003 Community Prevention Plan)

Priority One **Men Who Have Sex With Men**	**Priority Two** **Injecting Drug Users**	**Priority Three** **Heterosexuals**
MSM – General	IDU – General	HIV + IDU and partners
HIV+ MSM and partners	HIV + IDU and partners	Youth <24
Young MSM <24	Young IDU <24	Persons of Color (A.A., H/L)
MSM/IDU	Men of Color (A.A., H/L)	Female partners of high risk men, survival sex
MSM of Color (A.A., H/L, A.I.)	Needle Sharing	Incarcerated
Non (-Self) Identifying MSM	Homeless, legal issues or incarcerated	High risk or of unknown serostatus
Rural MSM	Survival sex or partners of IDU	
Migrant (Latino) MSM	Methamphetamine users	
Multiple sex partners, HIV- or unknown	Rural IDU	
Sex Traders		

Table 2

Priority One **Men Who Have Sex With Men**	**Priority Two** **Injecting Drug Users**	**Priority Three** **Heterosexuals**
~~MSM – General~~	~~IDU – General~~	HIV + IDU and partners
HIV+ MSM and partners	HIV + IDU and partners	Youth <24
Young MSM <24	Young IDU <24	Persons of Color (A.A., H/L)
MSM/IDU	Men of Color (A.A., H/L)	Female partners of high risk men, survival sex
MSM of Color (A.A., H/L, A.I.)	Needle Sharing	Incarcerated
Non (-Self) Identifying MSM	Homeless, legal issues or incarcerated	High risk or of unknown serostatus
Rural MSM	Survival sex or partners of IDU	
Migrant (Latino) MSM	Methamphetamine users	
Multiple sex partners, HIV- or unknown	Rural IDU	
Sex Traders		

Neither MSM-General or IDU-General are specific subpopulations. Thus, only repeat the general behavioral risk category.

Table 3

Priority One	Priority Two	Priority Three
Men Who Have Sex With Men	**Injecting Drug Users**	**Heterosexuals**
HIV+ MSM and partners	HIV + IDU and partners	HIV + and partners
Young MSM <24	Young IDU <24	Youth <24
MSM/IDU	Men of Color (A.A., H/L)	Persons of Color (A.A., H/L)
MSM of Color (A.A., H/L, A.I.)	Needle Sharing	Female partners of high risk men, survival sex
Non (-Self) Identifying MSM	Homeless, legal issues or incarcerated	Incarcerated
Rural MSM	Survival sex or partners of IDU	High risk or of unknown serostatus
Migrant (Latino) MSM	Methamphetamine users	
Multiple sex partners, HIV- or unknown	Rural IDU	
Sex Traders		

Prioritized populations by HIV status, then by behavioral risk category, and then by other subpopulation characteristic

Table 4

Priority One - HIV-Infected Persons	Priority Two – HIV Negative Persons or Persons of Unknown Serostatus		
	2a. Men Who Have Sex With Men	**2b. Injecting Drug Users**	**2c. Heterosexuals**
MSM and partners	Young MSM <24	Young IDU <24	Youth <24
IDU and partners	MSM/IDU	Men of Color (A.A., H/L)	Persons of Color (A.A., H/L)
Heterosexual and partners	MSM of Color (A.A., H/L, A.I.)	Needle Sharing	Female partners of high risk men, survival sex
	Non (-Self) Identifying MSM	Homeless, legal issues or incarcerated	Incarcerated
	Rural MSM	Survival sex or partners of IDU	High risk or of unknown serostatus
	Migrant (Latino) MSM	Methamphetamine users	
	Multiple sex partners, HIV- or unknown	Rural IDU	
	Sex Traders		

ATTACHMENT D

SPG Policies and Procedures Manual

WASHINGTON STATE HIV PREVENTION PLANNING GROUP

POLICIES AND PROCEDURES

MANUAL

May, 2003

A. MEMBERSHIP

1. DEFINITION OF MEMBERSHIP TYPES

a. Regional membership

Each region will select 3 representatives, for a total of 18, to the SPG. Regions are asked to balance their selections with the PIR needs of the SPG and representation from the affected/infected community, community-based organizations and health departments.

Regions may also select as many alternates as needed to assure adequate and balanced representation. Alternates should be kept aware of the SPG schedule and issues so they can attend and represent the region in place of the regular member.

b. At-large membership

Additional positions on the SPG will be filled by at-large members (12-14 members per 2002 charter revision). At-large members will be elected by the SPG through a recruitment, application and nomination process. The Nominations, Membership and PIR Committee will provide the initial screening and the SPG will make the final decision. DOH will appoint the elected members to the SPG. Members will be selected based on their qualifications, the PIR needs, and the vacancies on the SPG.

Organizations and agencies, which are represented on the SPG, may appoint alternates to attend SPG meetings when the regular representative is not available. It is, however, the responsibility of the organizations or agency to assure that the alternate is prepared to fully participate in the decision making process of the SPG.

c. Current membership information

It is critical that all mailing and contact information on members and alternates is current. If member's information changes, including email address, the member is asked to email or call DOH with the correct information.

2. MEMBERSHIP SUPPORT

Certain costs for meeting attendance will be either reimbursed or provided by DOH. If an alternate attends the meeting as a replacement for an absent regular member, then the alternate member's costs will be addressed in the same way as for regular members. If the alternate member attends the meeting, but is not replacing the regular member, then the region, agency or organization that the alternate represents will be responsible for associated costs.

a. Reimbursement

Reimbursement forms will be available at all meetings of the SPG. Reimbursement for the following expenses can be provided:

1. Round trip mileage from the members point of origin to the meeting site, paid at the current DOH mileage rate;
2. With the submission of a receipt, childcare expenses, pre-approved duplication of handouts and other pre-approved out-of-pocket expenses incurred in meeting attendance. Prior approval must be obtained from DOH.

b. Airfare and lodging

For members requiring airline transportation, the DOH office will arrange for e-tickets for the members from the closest or most convenient airport to SeaTac. Arrangements must be finalized prior to the day of travel by calling (360) 236-3424. The member may elect to utilize their own vehicle and receive mileage reimbursement, in lieu of airfare.

If a member has special needs or the travel arrangements dictate arrival on the day before a scheduled meeting, lodging may be provided by DOH. Prior approval and arrangements will be necessary.

When the meeting is scheduled for more than one day, lodging for members will be provided at the meeting site. Prior arrangements must be made to assure lodging availability.

c. Meals

If the agenda calls for a working lunch or the meeting involves more than one day, appropriate meals will be provided by DOH for members of the SPG.

No other meal costs will be reimbursed by DOH without prior arrangements and approval.

B. MEETINGS

All regular members of the SPG are expected to attend all meetings. If a regular member is unable to attend, appointed alternates are expected to attend in their place. Regardless of how many representatives are present, each region may have no more than a total of 3 votes and each at-large member, one vote.

1. AGENDA

Members will receive a draft agenda one week before the scheduled meeting date. This draft agenda will be prepared by the Executive Committee. Agenda items will be included based on input from the SPG membership, required actions in the decision making process and set agenda items, such as regional and other updates or reports.

2. OTHER MATERIALS

Prior to each meeting, members will receive a packet of information containing the draft agenda (which is also posted on the HIV Prevention and Education website), draft minutes for the last meeting and other support or informational materials. Members are expected to be familiar with agenda related materials that are distributed in this manner.

There are also many materials that are distributed at the meeting. Every effort will be made to assure adequate time to review those materials prior to discussion or decision making.

3. ATTENDANCE

All regular members are expected to attend SPG meetings. If a member finds that they will not be able to attend, the member should call or email the DOH office prior to the meeting. If prior notice is not possible, then a message through another member or to DOH is expected.

If the regular member cannot attend the meeting and there is a designated alternate available, then the alternate should attend. If travel or other arrangements need to be made, call DOH, as soon as possible.

No one except regular members or their designated alternate will be counted for attendance or allowed to vote (should a vote be taken).

Failure to notify DOH in a timely manner of the inability to attend a scheduled meeting will result in an unexcused absence. Because of the few meetings held by the SPG, any at-large member with 3 absences, whether excused or not, may be asked to resign. If a regional member has 3 absences, the appropriate contact for the regional planning group will be notified and the issue will be dealt with at the regional level.

The Nominations, Membership and PIR Committee will coordinate attendance and other membership issues.

4. DECISION MAKING AT MEETINGS

Decision making at the SPG is through consensus, except in the following instances:

a. Election of Vice-Chair: the election of the Vice-Chair will be held at the last meeting of the planning year. If only one candidate is being considered, then consensus will be the decision making process. If more than one candidate is being considered, then ballot voting will be utilized to determine the selection. Only regular members or designated alternates may vote for the Vice-Chair.

b. Nomination and Selection of Membership: Recommended applicants for at-large membership will be selected by the Nominations, Membership and PIR Committee. Candidates will have the opportunity to address the SPG concerning their request to be selected.

c. During the discussion and consensus determination of nominated applicant or Vice-Chair candidate(s), the applicants and candidates will be asked to leave the room. Once consensus is achieved or a vote is taken, the candidate(s)/applicant(s) will be asked to return to the meeting to hear the decision.

   If a candidate or applicant is not accepted by the SPG, an appeal process through the Nominations, Membership and PIR Committee is available. (See PIR Plan)

d. If consensus cannot be reached by the SPG, then the Community Co-chair will call for a voice, hand or ballot vote to reach a final decision. Simple majority, except where specific requirements are outlined in the Charter, will be the rule.

C. COMMITTEES

SPG members are expected to serve on standing or ad hoc committees throughout the planning year. Every effort will be made to arrange convenient methods and times for committee meetings. Non-SPG members can be recruited and serve on any ad hoc committee.

1. STANDING COMMITTEES

a. Executive Committee

The Executive Committee consists of the Community Co-Chair, Health Department Co-Chair, Vice Chair. DOH will staff the committee. The Executive Committee typically meets on a monthly basis through a conference call.

b. Nominations, Membership and PIR Committee

The Nominations, Membership and PIR Committee is chaired by the Community Co-Chair. Membership on this committee will be solicited, at least, annually at the first meeting and periodically, as needed, throughout the planning year. Meetings are at the discretion of the committee chair and may be face-to-face or on a conference call. DOH will staff the committee.

2. AD HOC COMMITTEES

Ad Hoc Committees to address planning and process issues will be formed throughout the planning year. The Vice Chair will chair all process committees. Other committees may be chaired by either the Vice Chair or a selected committee member. Meetings may be held face-to-face or on conference calls.

3. CAUCUS GROUPS

SPG members can, at their discretion, form special interest caucus groups for the purpose of representing a population, intervention or other issue of interest to the SPG and the planning process. Caucus groups that are formally recognized by the SPG will be supported, by DOH, to find rent-free space or conference calling accommodations, but no other related expenses will be covered.

4. REPORTING

All committees will keep written notes of the meetings. These notes will include time, method and attendees of the meeting; summaries of pertinent discussion and planning; recommendations to be brought to the SPG membership; and, follow-up details for continued work. A copy of the written notes will be sent to the Co-Chairs and DOH for inclusion in the SPG documentation. If appropriate, copies of the notes may also be distributed to the SPG membership.

D. OTHER POLICIES AND PROCEDURES

1. ROLES AND RESPONSIBILITIES

A definition and description of the roles and responsibilities of regional and at-large members is attached.

2. APPLICATION/SELECTION PROCESS FOR AT-LARGE MEMBERS

Applicants are solicited through a variety of recruitment processes. The most common are: a.) contact with agencies and organizations that provide statewide services that impact HIV; and, b.) through personal contact from members of the SPG.

Applicants submit their application to DOH, who then passes it on to the Nominations, Membership and PIR Committee. The Nominations, Membership and PIR Committee will consider all applications received and determine if the applicant can fill a need or vacancy identified as part of the PIR process.

If the applicant meets the need or vacancy on the SPG and has the qualifications to serve, the applicant will be presented to the SPG for selection. Final selection is by the SPG.

If the applicant does not meet the needs or vacancy on the SPG, the Nomination, Membership and PIR Committee will notify the person of the reasons that their application will not be brought to the SPG. This decision can be appealed by written request to the Nominations, Membership and PIR committee that includes the reasons the applicant feels that they can fill the identified need or vacancy.

3. CONFLICT OF INTEREST

Attached is a copy of the Charter of the Washington State HIV Prevention Planning Group (SPG). Please refer to Article 5, Section 5 for a definition of Conflict of Interest.

Any member that has a fiduciary, potential or present, interest in the decision before the SPG should openly declare that conflict of interest during the discussion of the subject and refrain from contributing to either consensus or voting by abstaining. The abstention should be noted in the minutes.

4. CONFIDENTIALITY

Every effort will be made to protect the personal information about SPG members. As a planning group for public funding, the names of members are a matter of public record. SPG members are asked to use discretion when sharing the membership list for any purpose. If organizations or other entities wish to contact the membership, they can request distribution of their information at the meeting or through our membership mailings. DOH is responsible for this distribution.

STATEMENT OF ROLES/RESPONSBILITIES OF SPG MEMBERS

The regional representatives to the SPG bridge the gap between the local planning process and the statewide perspective. Because the roles of the state planning group (SPG) and regional planning groups (RPG) are different, the regional representatives provide the following:

1. Active participation in both processes.
2. Information, perspective and advocacy for the regional issues while maintaining a statewide view.
3. Assistance to their respective RPG in applying and implementing the SPG guidance for the planning process.
4. Providing the linkages between information, activities and viewpoints at both the statewide and local levels.
5. A voice for the perspectives they represent, i.e. health department, community-based organization or infected/affected community) at both level of planning.
6. Leadership in the tiered planning process.

The at-large representatives on the SPG are chosen for their expertise or ability to represent communities identified in the PIR plan. Their roles include:

1. Active participation in the SPG process.
2. Provision of information, perspective and advocacy for the area of expertise or representation.
3. Interpretation of technical or scientific data to provide support for the planning process OR interpretation of community experience to provide support for the planning process.
4. Whenever possible, at-large members are encouraged to attend the regional planning groups meeting in the area and provide assistance to other regional planning groups, if needed.

All members, regional and at-large, are expected to:

1. Serve as active members of committees and regional review panels.
2. Whenever possible, members should consider attending the meetings of other regional groups and/or networking with other regional planning groups.
3. Provide support and mentoring for newer members of both the state and, respective, regional planning group.

ATTACHMENT E

HIV/AIDS Knowledge and Prevention Needs Assessment of Migrant Seasonal Farm Workers

HIV/AIDS Knowledge and Prevention Needs Assessment of Migrant Seasonal Farm Workers

Prepared for:

State of Washington
Department of Health

Prepared by:

Washington Association of Community & Migrant Health Centers

January 17th, 2003

INTRODUCTION

Latinos constitute the largest minority group in the United States (US Census Bureau, 2002). The incidence of HIV/AIDS continues to be high among male and female Latinos when compared to whites (CDC, 2001). In 2000, Hispanics represented 13% of the U.S. population (including residents of Puerto Rico), but accounted for 19% of the total number of new U.S. AIDS cases reported that year (CDC, 2000). Factors that increase their risk of exposure include multiple sex partners, men having sex with men, bi-sexual men, and injection drug use. Mexican seasonal migrant farm workers constitute one of the largest groups of Latinos in the State of Washington. There is limited information about HIV-related knowledge and risk behaviors among MSFWs in the State of Washington. There is little data available that specifically assess prevention strategies that are considered culturally appropriate by the MSFW population. The needs assessment was conducted to identify and describe the beliefs, knowledge, and prevention needs of Migrant Seasonal Farm workers (MSFW) about HIV/AIDS.

A seasonal farm worker (SFW) is an "individual whose principal employment is in agriculture on a seasonal basis and who has been so employed within the last twenty four months". In contrast, a migrant farm worker (MFW) "meets the same definition as a SFW but establishes, for the purpose of such employment, a temporary abode**"** (Enumeration Study Washington State 2000). In 2000 there were 186,976 migrant and seasonal farm workers (MSFW) employed in the agricultural industry in Washington State, according to a study commissioned by the Bureau of Primary Health Care Health (Enumeration Study Washington State 2000). There were 102,259 additional non-farmworker family members living in MSFW households during the same year. Thus, a total of 289,235 farmworkers and household members resided in Washington State in 2000. The majority of farm workers in this state are Latinos who have "settled out" or made their permanent home in Washington and travel within the state and other states following the various crops harvests. A smaller number (35%), migrate from other states and countries such as California, Texas, Mexico, Guatemala, Colombia, and other Central and South American Countries. Of those who migrate from other countries, the majority are men who leave their families to come to Washington State to harvest asparagus, cherries, peaches, apricots, and apples from April through early October.

In Washington State, Latinos comprise the largest group of migrant seasonal farm workers who are primarily represented by Mexicans and Mexican-Americans. The incidence of HIV/AIDS among seasonal farm workers in Washington State would be expected to be high because of several factors which include their transient working and migratory patterns, cultural beliefs and health practices, as we as literacy level and limited English proficiency (Aguirre-Molina, Molina, & Zambara 2000). Another factor that put men at risk is traveling within the state and/or from other state(s) without their partners, spouses and families in the early spring through early fall to work here. These men and women, in order to meet their sexual needs, are more likely to have the opportunity to engage in male with male sex and/or heterosexual contact with women who are not their partners. There is limited information about HIV-related knowledge and risk behaviors among MSFWs in the State of Washington. There is little data

available that specifically assess prevention methods that are considered culturally appropriate by the MSFW population.

This information was gathered by conducting focus groups in Spanish. Focus groups were conducted at migrant camps in four Washington state counties: Douglas-Chelan, Okanogan, Yakima, and Benton-Franklin. An incentive of a $25 gift certificate to buy groceries was given to participants of the focus groups. A total of 53 MSFW men and 32 MSFW women took part in the assessment. This needs assessment will provide valuable knowledge to the agencies that fund programs to develop community-based HIV/AIDS prevention programs for the migrant and seasonal farm workers in the state of Washington.

METHODS

A qualitative methodology was chosen for this study among migrant and seasonal farm worker men and women because of the exploratory and descriptive nature of the study objectives and goals. Separate focus groups were used to elicit information on HIV/AIDS prevention, knowledge and needs of participants. In addition, participants offered suggestions on culturally appropriate strategies to use when developing educational programs to deliver HIV/AIDS information to this population.

SAMPLE

Convenience samples of Latino seasonal/migrant men (n = 53) and women (n = 32) working in Eastern Washington between the months of July and October were invited to participate. Subjects were recruited from Douglas-Chelan County (n = 22), Okanogan County (n = 13), Yakima County (n = 34), and Benton-Franklin County (n = 16).

SAMPLING PROCEDURES

Recruitment sites were selected because they were representative of the targeted group and subjects were willing to participate in the study. Community outreach workers from the Migrant Health Centers and local health departments recruited subjects who represented one of the targeted groups. Potential subjects were approached on an individual basis at migrant camps after they returned from work. The recruitment process followed the protocol approved by the Washington State Internal Review Board (WSIRB) to protect subject's confidentiality. An explanation of the study was given and subjects were informed of the day, time and location of the focus group meeting. Each group was identified by a number. As an incentive to attend, participants received a meal 30 minutes prior to the discussion and a gift certificate for $25 from Safeway after the focus group discussion was completed.

MEASURES

Focus Groups

An open-ended semi-structured Spanish language questionnaire was used to guide the focus group discussion (see Appendix A). The questions elicited information on knowledge, attitudes and behaviors on HIV and AIDS prevention among participants. In addition, participants were asked about the type of prevention information they wanted to learn and the most culturally appropriate and effective methods to deliver the information. Each participant took turns to respond to each question.

Demographic Characteristics

Demographic data was collected with a survey after participants completed the discussion. Demographic characteristics that were assessed included gender, age, education, subject and subject's parents birth place, last place of work, next place of work, place of living, years working in Washington state, years working in the U.S., years living in the U.S. and annual income. Education was coded on an 8-point scale. The education scale categories were: "1" = 1st to 3rd grade (primaria), "2" = 4th to 8th grade (intermedia), "3" = 9th to 12th grade (secundaria), "4" = technical school, "5" = two years of college, "6" = four years of college (bachillerato), "7" = graduate school, and "8" = medical/doctorate.

Procedures

The focus groups were carried out in four different counties in Eastern Washington. Dates, times, locations of the groups as well as the facility were chosen to accommodate the working schedules of participants (Table 1). Group discussions were conducted in the evening and in a private area of the camps or clinics.

Table 1 Group Schedule and Setting

Site	Date and Time	Group	Setting
Douglas-Chelan County	July'02- 6:30- 8:00 PM	Men	Migrant camp
Okanogan County	July'02- 6:00- 7:30 PM	Women/Men	Clinic rooms
Yakima County	August'02 5:30- 7:00 PM	Women/Men	Outreach program Mobile home/Migrant residence
Benton-Franklin County	September'02 6:30- 8:00 PM	Women/Men	Migrant camp
Douglas-Chelan County	October'02 6:00- 7:30 PM	Men	Migrant camp
Douglas-Chelan County	October'02 7:45- 9:00 PM	Men	Migrant camp
Yakima County	October'02 6:00- 8:00	Women/Men	Migrant camp

All of the focus groups were conducted in Spanish and recorded on audiotape. A male Latino Health Specialist from the WACMHC facilitated the discussion with the male participants. An independent research consultant for the WACMHC facilitated the discussion with the female participants. All the audiotapes were transcribed in Spanish and then translated to English by the research consultant.

The group discussions began by giving a detailed explanation of the study using the guidelines approved by the Washington State Internal Review Board (WSIRB). Participants were asked not to discuss personal information and reminded that the information shared by participants was confidential. It was explained to the subjects that we were not looking for right or wrong answers and that they could choose not to answer a question without being penalized.

The first segment of the discussion began by asking participants what they knew about AIDS and HIV and how they learned about it. The second segment elicited their opinions about behaviors that put people at risk for getting AIDS, preventive measures or things people do in order to avoid contracting AIDS, and attitudes towards HIV/AIDS. The last segment of the session involved generating ideas about the types of prevention information they want to learn about HIV/AIDS. They were also asked to suggest culturally appropriate methods, themes and approaches to inform migrant health workers about risky sexual behavior and the use of prevention practices. This was followed by a brief discussion of how and when this information should be given and who should deliver it. Each group session lasted about an hour and a half (1 1/2). Lastly, the investigators collected demographic data on each participant on an individual basis using a semi-structured survey. Participants were thanked and compensated for their participation with a gift certificate and written prevention literature in Spanish.

Data Analysis

Descriptive statistics were used to analyze the demographic data. Content analysis of the data generated by the focus group discussions was done using a hermeneutics approach (Denzin & Lincoln, 1999; Morgan, 1997). That is, verbatim texts and audiotapes were carefully reviewed on multiple occasions. Data collection and analysis were considered to be a dialectical process. The analyses started with the first interview where answers were reviewed and used to elicit information about the following group discussions. Categories and themes were identified and summarized. This data was then shared with some of the groups in order to receive feedback and gain deeper knowledge about the themes and patterns identified. Data was translated into English by the research consultant and verified by the Latino Health Specialist in order to report the findings. The terms used in the final report were validated by a bilingual health care professional and reflect the most accurate expressions captured by the discussions.

RESULTS

Sample Demographics Characteristics

The two samples were compared on age, education, place of birth, place of birth of parents and yearly income (Table 2). The female sample was older (M=32.4) than the male sample (M=29.8). Both male and female subjects had three years of education or less (69.8% and 65.5% respectively). Male subjects were more likely to have completed High School than their female counterparts (19.8% and 15.6% respectively). Female subjects were more likely to have two or more years of college education than male subjects (9.3% and 1.9% respectively). Almost all subjects and their parents were born in Mexico (95.3% and 98.8% respectively). Men were more likely to have higher yearly incomes than women.

Table2 Characteristics of participants

Variables	*Female (n=32) N (%)*	*Male (n=53) N (%)*	*Female (n=32) mean (SD)*	*Male (n=53) mean (SD)*
Age (years)			***32.4 (13.3)***	***29.8 (11.5)***
Education				
Primary	***21 (65.6)***	***37 (69.8)***		
Intermediate	***3 (9.4)***	***3 (5.7)***		
High school	***5 (15.6)***	***10 (18.9)***		
Technical	***0 (0)***	***1 (1.9)***		
2 years of college	***1 (3.1)***	***0 (0)***		
Bachelor degree	***1 (3.1)***	***1 (1.9)***		
Graduate school	***1 (3.1)***	***0 (0)***		
Missing		***1 (1.9)***		
Country born				
Mexico	***28 (87.5)***	***53 (100)***		
U. S.	***4 (12.5)***	***0 (0)***		
Country parents born				
Mexico	***31 (96.9)***	***53 (100)***		
U. S.	***1 (3.1)***			
Yearly income (K)				
0-5K	***14 (43.8)***	***8 (15.1)***		
6-10K	***9 (28.1)***	***22 (41.5)***		
11-20K	***5 (15.6)***	***9 (17.0)***		
21-30K	***0 (0)***	***1 (1.9)***		
31-40K	***0 (0)***	***1 (1.9)***		
Missing	***4 (12.5)***	***12 (22.6)***		

NOTE:

*All italicized words or phrases are direct quotes from the focus group participants.

**Due to the qualitative characteristics of the data the following terms were used to report the findings. The term "all" was used when more than 100% of participants responded in the same manner or agreed. The term "most" was used when more than 80% of participants responded in the same manner or agreed. The term "some" was used when at least 45% of participants responded in the same manner or agreed. The term "few" reflects the opinion of less than 10% of participants.

Working patterns and length of time living and working in the U. S. were also compared between the two samples (Table 3 & 4). Female subjects had been working longer in Washington State and the U. S. (M=7.3 and 9.5 respectively) than their male counterparts (M= 6.8 and 8.3 respectively). Female subjects had lived longer in the U.S. (M=13.3) than male subjects (M=7.8). Most male subjects had worked in California (34%), other parts of Washington State (30.2%) and Mexico (26.4%) before coming to Eastern Washington. In contrast, half of the female subjects had worked in Washington (50%) and Mexico (12.5%) before coming to Eastern Washington. Some male and female subjects had worked in Arizona, Illinois, Mexico, Nevada, Oregon and Texas before coming to work to Eastern Washington. Female subjects (75%) were going to stay in Eastern Washington to work, whereas less than half of the male subjects (43.4%) were going to work in Washington. Thirty-Four of male subject were going to work in California after the season was over. More than seventy-five percent of the female subjects (78.1%) live in Washington State, Mexico (15.6%) and Texas (6.3%) most of the time. Male subjects live most of the time in Washington (45.3%), Mexico (28.3%) and California (26.4%).

Table 3 Working Patterns by State

Variables	*Female (n=32) N (%)*	*Male (n=53) N (%)*
Where did you work before?		
California	***3 (9.4)***	***18 (34.0)***
Washington	***16 (50.0)***	***16 (30.2)***
Texas	***2 (6.3)***	***0 (0)***
Oregon	***1 (3.1)***	***1 (1.9)***
Mexico	***4 (12.5)***	***14 (26.4)***
Arizona	***0 (0)***	***1 (1.9)***
Nevada	***0 (0)***	***1 (1.9)***
Others	***1 (3.1)***	***1 (1.9)***
Missing	***5 (15.6)***	***1 (1.9)***
Where are you going to work later?		
California	***0 (0)***	***18 (34.0)***
Washington	***24 (75)***	***23 (43.4)***
Oregon	***0 (0)***	***3 (5.7)***
Mexico	***0 (0)***	***5 (9.4)***
Missing	***8 (25)***	***4 (7.5)***
Where do you live most of the time?		
California	***0 (0)***	***14 (26.4)***
Washington	***25 (78.1)***	***24 (45.3)***
Texas	***2 (5)***	***0 (0)***
Mexico	***5 (15.6)***	***15 (28.3)***

Table 4 Length of time working and living in U. S. in years

Variables	*Female (n=32) mean (SD)*	*Male (n=53) mean (SD)*
Number of years worked in WA	***7.3 (6.9)***	***6.8 (6.4)***
Number of years worked in the US	***9.5 (8.5)***	***8.3 (7.0)***
Number of years lived in the US	***13.3 (13.9)***	***7.8 (7.1)***

Study findings reflect the experience of the subjects in this sample and should not be generalized to other MSFW groups. The data provides insightful information about what participants are learning and know about HIV/AIDS prevention and how this information is being acquired. We also gained insight into some of the cultural beliefs and attitudes that are considered barriers and assets that can be used to develop strategies to refine and expand health prevention programs.

Knowledge about AIDS

Most of the female and male participants consistently described AIDS as a *disease (enfermedad)*. A few participants *did not know* what AIDS is. Yet others compared AIDS with cancer and identified it as a *venereal* disease. Those who responded that AIDS is a disease used specific words to emphasize the life-threatening aspect of the disease. Some refer to AIDS as a *dangerous* and *serious* disease. That is *fatal*, *mortal* and that it *kills* people. Participants also referred to AIDS as "*incurable"* and a *virus* that is *difficult to control*.

- Responses to "What is AIDS?":
    - Dangerous
    - Grave
    - It kills people
    - Mortal
    - Contagious
    - Causes death
    - Incurable
    - Damaging
    - Serious
    - It's like cancer but worse
- Don't know
- A virus

Knowledge about HIV

Most participants also identified HIV as a *disease*. In addition, participants used some of the same terms used to described AIDS to described what HIV meant to them. Many expressed that HIV and AIDS are *the same thing* or that they *did not know* what it is. Some participants responded that HIV is *the initial stage of AIDS* but the disease is *not in full force yet*. Many expressed confusion about the difference between HIV and AIDS. For some participants HIV meant *the carrier of the disease* (AIDS) or that the *disease comes first and then the virus*. The few participants who distinguished HIV as a *virus* and AIDS as a *disease* tended to have more years of education. They also participated in HIV/AIDS information sessions here in the U.S. and Mexico.

Responses to "What is HIV?":

- A disease
    - Mortal
    - Contagious
    - Causes death
    - Incurable
- Don't know
- The same as AIDS
- Initial stage of AIDS
- You are contaminated
- Not the same as the disease (AIDS)
- More advanced
- HIV is the beginning
- I am not sure

Where participants learned about HIV/AIDS

The majority of male and female participants learned or heard about HIV/AIDS from informal conversations with family members such as their children who learned about it at school, health care professionals in clinics and hospitals, outreach workers, friends, centers where preventative information was available, and through the media. Media examples included a Spanish soap opera, TV reality shows and radio programs where they can call to ask questions. Written information, such as pamphlets, was not mentioned much as a conduit of information. Reasons for not using written information to learn about AIDS included not being able to read or write in English or Spanish, and level of understanding of terms used.

Responses to "Where have you learned about HIV/AIDS?":

- Family members
    - Uncle
    - Own children
- Media
    - TV soap opera
    - TV announcement
    - Radio (Spanish)
    - Advertisements
    - Newspapers
    - Pamphlets
- Outreach Programs
    - Community-based educational program (DOH)
    - Clinics
    - Hospital
    - Mobile van
- Health Professionals
    - Social worker
    - Doctor

    - Nurse
    - Case manager
- Others
    - Friends
    - People in the camps

Talking to family about AIDS/HIV

The vast majority of female and male participants felt that they could not talk about this topic with family members such as children and youth. Almost all participants expressed that they do not feel comfortable talking to their family about the sexual behaviors that might put them at risk for getting AIDS. Some of the reasons consistently mentioned by both men and women were; being embarrassed and ashamed to use the term sex or sexual relations, not having the skills or knowing how to start a conversation about this topic, not having educated parents talk to them about sex when they were children, and feeling that they do not have the capacity or knowledge to answer more specific questions if asked about AIDS. A small number of participants articulated that they have talked about risk and preventive sexual behaviors to their older children. This group of participants had three things in common: they had been living in the U.S. for more than 15 years, were able to speak English, and/or had at least a High School education. The groups were nearly unanimous in their need to develop the capacity to be prepared *(estar capacitado/preparado)* to talk to their children about this topic.

Almost all participants agreed that men and women should have an HIV/AIDS conversation separately. The also agreed that mothers should talk to their daughters and fathers to their sons about HIV/AIDS. Very few participants expressed the need for husbands and wives to have a conversation about the things one should do or not do to avoid getting HIV/AIDS. Yet there was consistent reaffirmation by both men and women that the Mexican cultural value of "machismo" was a factor that negatively influences the ability of couples to engage in a conversation about risk behaviors and HIV/AIDS. Men consistently admitted that *their doing (lo que hacemos)* was putting them and their partners at risk for getting *this disease* or being *infected*. That is, having *sexual contact* or *getting together with women* other than their wives/partners or *having sex with other men*. The most salient suggestion given to try to counteract this behavior was to have regular, multiple face-to-face informational sessions and discussions about prevention of HIV/AIDS. Hearing this information over and over again was considered an effective teaching strategy among the men. Conversely, the women explained that the men are not willing to participate in educational sessions as much as they are unless they are paid to attend.

Responses to "Do you talk about AIDS/HIV with your family?":

- Reasons MSFWs do not talk to their families about HIV/AIDS.
    - Not feeing comfortable talking about sex
    - Being embarrassed
    - Being ashamed use terms like sex or sexual relations
    - Not skilled at starting conversations

- Not having a role that (parents) who talked to them about HIV/AIDS
- Not knowledgeable enough to answer specific question that some might ask about the disease

Causes of AIDS

The number one cause of AIDS articulated over and over in each group was *having a sexual relation with someone who is infected* with the disease *without using protection*. Being with prostitutes or other women besides the wife or partner was also thought of as a way of getting infected with AIDS. The majority of the men expressed that AIDS is mostly transmitted by women but that some men, such as homosexuals, can also pass it on. Some participants also mentioned that the exchange of body fluids between people also causes AIDS. Examples of this included using the same needles that drug addicts use to inject drugs, blood transfusions and contaminated blood coming in direct contact with open skin.

There seemed to be misconceptions among some participants about other causes of AIDS. For example, some participants in each group indicated that AIDS is caused by kissing someone with AIDS, bathing in the same shower used earlier by someone with AIDS, drinking from contaminated cups, using eating utensils used by someone with AIDS, sharing shaving instruments, using toilets, by mosquito bites, and using someone else's toothbrush. When further probed, the participants were vague about where they had heard or learned this information. Participants expressed that they have heard this information on the street from people, acquaintances, or friends.

Responses to "What causes AIDS?":

- Exchange of bodily fluids
  - Having sexual relations with prostitutes
  - Having sexual relations with other women other than wife
  - Having sexual relations without protection (condom)
  - Men having sex with other men
  - Drug addicts with AIDS sharing needles
  - Receiving blood transfusion
  - Contaminated blood or saliva making contact with open skin
- Other
  - Kissing someone with AIDS
  - Giving blood
  - Drinking from a contaminated cup
  - Using contaminated eating utensils
  - Sharing shaving instruments
  - From toilets
  - Using someone else's toothbrush
  - From infected dental instruments
  - Lack of hygiene and not bathing

- Mosquito bite

- Don't know

Reasons people get AIDS

The primary reason people get AIDS given in each group was having *a sexual relation without a condom* with someone who is *infected*. This was discussed within the context of *not being careful* and *being unfaithful,* which are considered inappropriate behaviors. Most of the female participants contended that *sleeping around* was the primary reason for getting AIDS. Two worrisome characteristics that came out in some of the women's group were related to the Mexican cultural belief of being *too macho to use a condom and being unfaithful,* which was explained as a behavior that most Mexican men exhibit. In one group some of the women gave examples of Mexican sayings (aphorisms) that the men use to justify these behaviors. For example, they explained that men refer to using a condom during intercourse as *eating a banana with the peel on* or *eating a sucker with the wrapping on*. There was a sense among the women that they had to *trust* their men are going to be careful and use protection when having sex outside of the marriage. A few women added that "*it is a disappointment"* to know that the men don't use a condom when they have sex with other women.

The men also voiced that *not being careful* and *not using* protection is why people get contaminated. A correlated pattern emerged in some groups when men expressed that *drinking alcohol* and *having unprotected sex* is a problem for some of them. When further probed they articulated that drinking alcohol *relaxes you and make things easier*. Some men also uttered that men know they are not being *careful* and *responsible when behaving this way.* Looking for sex outside of marriage, going to bars (cantinas) and getting involved with women who patronize these establishments were reported as the way some Mexican men tend to behave. Older men also reported that among the young men there is a feeling of invincibility that put them at risk for getting AIDS. A few men explained that some Mexicans believe that *they are going to eventually die* and that the *women look good,* therefore they are careless. In the Mexican culture death is believed to be a part of life, and that it should not be feared.

In few instances, *not knowing how to use a condom* was reported as a reason for getting AIDS. Not being able to access or buy condoms in confidence, also made it more difficult for some men to use protection. This was considered a barrier to prevention, especially at campsites that are inaccessible to outreach workers from clinics or mobile vans. These resources are considered by most men as one of the best ways for accessing condoms.

The few men who expressed not knowing how people get AIDS were older and had not been exposed to AIDS education as much as the younger ones. Some female participants regard older men as behaving in *more typical Mexican ways* and being *more difficult to teach to use a condom*. This traditional behavior is reported to be mostly observed in men who come from remote villages or ranches in Mexico.

Responses to "Why people get AIDS?":

- Having sex with prostitutes
- Having sex with homosexuals/another man
- Getting together with other women (non-spouse)
- For not being careful (not using protection)
- For not being careful at bars and parties
- Drinking alcohol
    - Relaxes
    - Make things easier (having sex)
- Getting involved without knowing that the person is contaminated
- Infected mothers feeding their babies with breast milk
- Mothers who are infected give it to the child
- For not having monogamous relations
- Transfusions
- Young men feel invincible
- Health workers with infected needles
- Not knowing how to use a condom
- I don't know

Preventing AIDS

There were two primary prevention behaviors that were repeated in nearly every group, taking precautions and using protection. Taking *precautions* was the one mentioned the most. Participants considered that certain personal and social behaviors were necessary in order to practice *precaution*. At the personal level men expressed that *using condoms* is what they should do in order to protect themselves. Some women also expressed that men should *use condoms*. The majority of women mentioned that it was difficult to ask their partners/husbands to use a condom when having intercourse with them because the men would be suspicious about their motive for such a request. Both groups felt strongly about taking personal responsibility for being *tested for HIV/AIDS* especially if they were engaging in risky sexual behaviors.

Being *truthful* to one's partner about having HIV, taking the initiative to *become informed,* and *knowing what to do* were also considered necessary preventive personal behaviors by most female participants. Some women expressed that Mexican men could *not be trusted* because they *don't like using condoms*. There was a sense of vulnerability among the women who felt this way. They added that most of the time *men refuse to go to discussions* about HIV/AIDS.

Taking precautions during social encounters were discussed within the context of inappropriate sexual behavior. Most participants acknowledged that *abstinence* and *faithfulness* between couples is what a person can do to prevent AIDS especially if an opportunity to have sex with someone else presents itself.

Responses to "What Can People do to Prevent AIDS?"

- Taking precautions
  - Personal
    - Using condoms
    - Being tested
    - Informing partner if HIV positive
    - Be informed
    - Know what to do
    - Truthfulness
    - Don't trust men and protect self
  - Social
    - Share knowledge with others
    - Abstinence
    - Faithfulness

HIV/AIDS Testing

There was consensus among all participants that everyone who engages in risky behaviors such as sexual intercourse with prostitutes, other women/men and homosexuals, receiving blood transfusions, and injecting drugs with infected needles should be tested. The discussion about whom to test and when to test also raised some important issues. Some participants expressed that everyone, even those who do not have *sexual relations with other men and women* outside of the marriage, should be tested.

Some participants felt that the *cost* and *availability of testing sites* was a barrier. Others expressed that going to be tested could be considered a stigma. That is, others may view this behavior as an *admission of culpability for their errors*. Protecting the confidentiality of the individual was another barrier identified. Some participants said that once the word is out, that a person went to be tested for HIV, people would behave differently towards that person. When further probed, some participants expressed that they have known someone who was asked not to come back to work at a field when the owner learned that the person was HIV positive.

Almost all participants verbalized that HIV testing should be offered to all migrant workers as part of the first physical exam they receive early in the season when they arrive to work in the fields. Many felt that the farm owners should offer this service near the fields or at the camps where most people live. Many support the idea of a mobile van where they can go to be tested instead of going to a clinic. The sentiment of the groups was that as long as there was discretion by the part of the health professionals doing the exam people will most likely agree to be tested. Some expressed that Latinos are *too embarrassed to go to a local clinic* to be tested and thus, *some people go to other towns* to be tested where *no one knows them*.

The majority of participants did not know people with HIV/AIDS or have not seen someone with signs and symptoms of the disease. Few participants knew someone who

had AIDS. Those who knew someone with AIDS expressed that everyone they knew were able to access and received appropriate treatment for AIDS.

Responses to "When should a person be tested for HIV/AIDS?":

- When a man has sexual relations with a lot of women
- When a man has sexual relations with another man
- When using infected needles to inject drugs
- After receiving a blood transfusion
- Every two to three years
- Anyone who has been exposed
- Everyone should be tested
- To know if one has the disease or not

Signs and Symptoms of HIV/AIDS

All the groups described some of the physical symptoms of AIDS that commonly occur during the late stage of the disease. The main difference among the groups was that men were more specific than women in describing how someone with AIDS looks like at that stage. Some women explained that a person with visible signs of the disease is predisposed to be rejected by others. Symptoms such as skinny, weak, lack of appetite, tiredness, diarrhea, paleness, brown skin spots, weight loss, cold symptoms (*gripa*) and hair loss were cited by most male participants and some female participants depicted someone with AIDS. All the groups recognized that they could not identify signs of HIV or the early stages of AIDS. Some young male participants expressed that it was *worrisome to not know* how to recognize someone at that early stage because of the risk of getting infected.

Responses to "What are the Signs and Symptoms of HIV/AIDS?":

- Skinny
- Weak
- Lack of appetite
- Tiredness
- Diarrhea
- Paleness
- Brown skin spots
- Weight loss
- Cold symptoms (*gripa*)
- Hair loss
- Can't tell
- Don't know

Type of information migrants want to know about AIDS

The information all of the groups wanted to know the most centered around two themes, prevention methods and behaviors people need to do to prevent the disease. Male

participants wanted to know about the things they need to do to prevent getting contaminated with AIDS such as *the proper methods to put on and use a condom*. Women participants also supported what the men stated and added that they wanted information that emphasizes responsible behavior such as *thinking before having a sexual relation* and *practicing fidelity between couples*. A few young male participants wanted information about how Immigration and Naturalization Services (INS) deal with undocumented migrant workers who test positive for HIV/AIDS.

Responses to "Type of Information Migrants Want to Know about AIDS".

- Prevention
    - Primary
        - Types of protection
        - How to use a condom
        - Ways people can get infected
        - Messages about responsible behavior
            - How to have fun with limits
            - Don't drink
            - Think before you act
            - Don't live *la vida loca*
            - How to talk to men so they protect their partner
            - How to bring up the subject with children/adults
    - Secondary Prevention
        - Where to go for testing in confidence
        - Cost of testing
        - What to do if HIV positive
            - Treatment available
            - Where to go for treatment
            - Prospect in life (prognosis)
- Other information
    - Time when one can avoid the disease
    - Immigration and Naturalization Services (INS) implications

<u>Preferred ways of receiving information about HIV/AIDS</u>

Most participants endorsed the use of various educational methods as the most effective way to deliver the information. Participants acknowledged that many people don't read and/or write in English and/or Spanish. Pamphlets with written information were not considered a very effective way to deliver the message to the majority of this population due to low literacy. Groups consistently expressed that visual aids such as videos, movies and personal testimonies are a more powerful way to convey prevention information.

Groups persistently agreed that seeing a real personal situation would be more effective in modifying behavior, especially among Mexican young men who might feel *invincible*. Many participants preferred to see a movie or video in Spanish that portrays the story of a

man or woman who is HIV positive or has AIDS. The majority expressed that they have never seen anyone with the disease. Seeing how someone with AIDS looks like would deter them from getting involved in behaviors that would put them at risk.

Some groups said that listening to the testimony of someone with AIDS would also make people *more conscientious and fearful*. For example, a small number of men had participated in traffic school where they had seen footage of car accidents where people had been seriously injured or killed and suggested such a strategy to *scare* people. Their sentiment was that seeing films with real accident situations left a powerful impression on them. Another suggestion given by the majority of participants was to *seek the support of farm owners* in developing a collaborative prevention program. Several men have participated in programs in California where farm owners allowed them to have radios in the field and listen to educational programs sponsored by HIV/AIDS educational agencies. Others have worked on farms where the farm owner made it mandatory for farm workers to receive HIV/AIDS education. They felt this program was successful in making men *feel supported* to take more responsibility for their behavior.

Responses to "Preferred ways of Receiving Information about AIDS?".

- Education in Spanish through (how)
    - Organize entertainment
    - Videos, movies, soap operas
    - Group discussions (*charlas*)
    - Separate men and women
    - Discussion of 2 or 3 points at a time
    - Personal testimonies
    - Radio calling show
    - Listening to radio shows while they work in fields
    - A school at the camp sites
    - Mandatory education at work place (fields)

- Education by:
    - Someone who has AIDS
    - Health care professionals
        - Social worker
        - Nurse
        - Doctor
    - A well trained community leader

- Education at:
    - A school at the camp site
    - In collaboration with farm owners at site
    - Mobile vans

- When to do education:
    - In the evening after work
    - On Sunday after church

- At a public accessible place
- Weekly

Barriers to Education

Some barriers to having educational programs for migrants were identified during discussions with some groups. Few participants expressed being fearful of attending meetings because the INS might come and deport them. The migratory pattern is also considered a problem to maintaining consistency in attending educational programs. Language and level of literacy was a prevailing difficulty for most group members. Some men expressed that they feel *embarrassed* about listening to information that reflects unsafe behaviors in which they might have engaged. This feeling was common among the men who consider themselves *hard headed and who don't want to listen* to safe sexual behavior advice. When asked what educational prevention programs can do to change or modify this behavior, men said that *repeating the information over and over* might be a good way for them to listen. Opposition from farm owners to support access to educational programs was also mentioned as a barrier for learning preventive information. Working long hours, living and working in remote sites, and limited means of transportation were also considered obstacles. Consenting to be tested for HIV was considered an admission to engaging in risky sexual behavior. These barriers need to be considered when planning and implementing prevention programs.

Assets to Education

During discussions both cultural and personal factors were identified as assets that facilitate the educational process in this population. Examples of these were willingness to participate and learn prevention behaviors and being receptive to different cultural ways of communicating with spouses and children about sexual topics. They wanted to develop the skills to initiate informed conversations about HIV/AIDS prevention with spouse/partners and families. Most of the participants also admitted that they have cultural beliefs that prevent them from changing their behavior. Therefore, they needed and want to change this attitude. Most single men travel together and interact as a family. A familiar environment can facilitate discussions of this content in a more comfortable way than having to go to a clinic or attending an educational program.

SUMMARY

This study assessed the HIV prevention needs of a sample of male and female migrant seasonal farm workers (MSFWs) in the state of Washington. In addition, it examined the sources of information on HIV/AIDS and the educational preferences to learn preventive information. MSFW identified HIV/AIDS as a disease that is contracted through unprotected sexual intercourse and blood transfusions from someone who has the virus. Most of the information about HIV/AIDS was learned through the media and from informal conversations with friends and families. A few of the participants, who were recent migrants, did not know what HIV/AIDS is. Participants were also unclear about the difference between the HIV virus and AIDS.

Risky sexual behavior was not considered a comfortable topic of conversation among the participants. Not having enough knowledge about HIV/AIDS and feeling embarrassed were reasons for not talking about it. However, participants wanted to learn more and feel proficient in discussing this topic. Most of the causes of HIV/AIDS were accurately identified. Inaccurate knowledge of the causes of HIV/AIDS among some participants came from informal sources such as acquaintances. Getting HIV/AIDS was attributed to some cultural practices such as "machismo" and engaging in behaviors that reflect lack of personal integrity and consideration to others.

The attitude that prostitutes and homosexuals were the major carriers of the HIV virus was prevalent among both men and women. Social and personal behaviors were considered the most effective way to prevent AIDS. Protective barriers such as using a condom during intercourse were correctly identified. However, some participants lacked the knowledge and skills to use one. Participants positively identified when people should be tested for HIV. However, access and cost was a precluding factor for being tested. The late signs and symptoms of AIDS were recognized despite the fact that the majority of participants had never seen anyone with the disease. Primary prevention information was preferred by the migrant sample. The use of cultural celebrations with entertainment and media were educational strategies favored by participants. Barriers to prevention as well as cultural and social assets of the population were acknowledged as important factors for the effective implementation of HIV/AIDS prevention programs.

DISCUSSION

The findings of this study support earlier reports (Kaiser Foundation, 2001) which suggest that Latinos have knowledge that AIDS is an infectious disease. The participants also know about prevention behaviors related to HIV/AIDS but want to become more proficient (*capacitados*) in talking about sexual behaviors with their partners and their families. Already existing community-based prevention programs and outreach strategies targeted to the MSFW population might explain this finding (J. Vela, personal communication, September 18, 2002). Groups could not differentiate between the HIV virus and AIDS. The same characteristics were attributed to both the HIV virus and AIDS. This finding is supported by Ford, King, Nerenberg & Rojo (2001) who reported that Midwest farm workers were not able to differentiate the terms AIDS and HIV.

Most of the information participants learned about HIV/AIDS were through informal interactions and multiple media sources. Informal sources of information about HIV/AIDS for men of Mexican origin were considered an effective way of educating this population (Carrier & Magaña, 1991). In our study, fotonovelas (comic strip format), radionovelas and radio calling programs were favored media sources of information. Fotonovelas have been successful with MSFW because they tell a story with very few words and use pictures depicting characters to get the point across. The fotonovelas proved to be very successful, not only as a means of communicating high-risk behavior and HIV infection to Latinos in Orange County, but also at the state level (Carrier, 1991). Both strategies were preferred over written educational materials. These preferences

might be a sign of the low literacy level of this population. It might also reflect the need to use an entertaining way to ease the stress of learning about a very serious topic.

Both men and women stated that they would like to have separate discussion groups. Also, there was a prevalent belief that men should talk to their sons and that women should talk to their daughters about HIV/AIDS. Both men and women agreed that the Mexican culture value of "machismo" was a barrier that prevented couples from discussing risky behaviors and HIV/AIDS. These findings suggest that cultural and gender norms play an important role on how men and women communicate with each other about HIV/AIDS (Marín, Gómez, Tschann & Gregorich, 1997). Participants did not favor talking with family members about sexual topics such as behaviors that put people at risk for HIV/AIDS. However, subjects were motivated to learn how to dialogue freely with family members, such as children, about sexual risky behaviors and HIV/AIDS. The process of acculturation might be a significant factor motivating this way of thinking. As people become more exposed to other cultural norms they tend to acquire the values of the majority group (Marín & Marín, 1990).

Most participants stated valid causes of HIV/AIDS, with exchange of bodily fluids being the most predominant cause mentioned. Misconceptions about what causes HIV/AIDS were also found in this MSFW groups. These findings support similar results from surveys conducted with Mexicans in California that found that migrants knew how HIV/AIDS was transferred. Subjects also believe that HIV/AIDS could also be transferred through casual modes (Organista, et al., 1997). Reasons given to why people get AIDS were consistent with findings from other studies (Carrier, 1989; Catania, Kegeles & Coates, 1990). The attitude among both men and women was that risky sexual behaviors and not using protective barriers were inappropriate behaviors. Many of the risk factors that are found in studies conducted in other states can also be attributed to MSFW in Washington State. For example, MSFW are young and leave their families in their home state and/or country. Many may develop conditions of prolonged loneliness, isolation and deprivation of affection (Bronfman & Minello, 1992; Organista & Organista, 1997). This psychosocial conditions could lead men to engage in risky behaviors with women who are not their partners, prostitutes, and having sex with men. This study also revealed that alcohol consumption is a contributing factor for engaging in sexual risk behavior. A socially isolated outlook on migrant life may lead the men to use alcohol as a form of coping with their feelings (Caetano, Schafer& Cunradi, 1995). There is a strong body of literature that suggests that feelings of depression are related to alcohol consumption (National Institute on Alcohol Abuse and Alcoholism, 2002). In this study, alcohol consumption was reported to be high among migrants and used as a way to pass time or entertainment.

The Latino culture may contribute to the increasing number of Latinos with HIV/AIDS through several traditional beliefs (Marín & Gómez, 1999). As reported by the participants, sexual issues tend to be taboo and are not discussed by parents with their children, or considered a topic of discussion between husband and wife. Moreover, there is a strong cultural belief that men can and should have multiple sex partners even when married. The attitude of most men is that women should accept this behavior even if it

puts the women at risk for getting a sexually transmitted disease. This attitude might make women feel intimated and increase their vulnerability to violence against them if they disagree (Gómez & Marín, 1996; Díaz, 1998). Another significant finding was the conviction of some male and female participants that prostitutes and homosexuals are the ones responsible for transmitting HIV/AIDS to others. This association might be a sign of a cultural attitude that rejects these sexual life styles among this population (Díaz, 1998).

A prevalent cultural belief among participants was that wearing condoms interferes with the pleasure experience in an intimate encounter. Sexual partners might tend to sanction men who use condoms and refer to them as not being macho enough (Diaz, 1998). This finding reflects a high tolerance by many in this community for risky behaviors. This behavior is also reported to be responsible for increased unwanted pregnancies, sexually transmitted diseases and HIV cases among young Latinos (National Latina Institute for Reproductive Health 2001). Not knowing how to use condoms could also be explained by the lack or limited exposure to prevention methods that many MSFW from rural areas in Mexico experience.

Migrant and seasonal farm workers are a difficult population to reach. Many MSFW are monolingual Spanish speaking, have low literacy levels, lack transportation, work long hours, live in rural areas far from health services, are very mobile and many are undocumented. All these barriers prevent many health services and health education efforts from reaching this population (Pinzón & Pérez, 1997). Studies that have examined issues of prevention with Latino populations suggest that educational programs should be conducted in their primary language (Spanish), at the camps and/or at the work sites. Bringing education to the farm workers through outreach programs and insuring that it will be conducted in the language that they will understand will minimize many of the barriers that this community faces (Denboba, Bragdon, Epstein, Garthright, & McCann Goldman, 1998; Porter & Villaruel, 1993).

The fact that MSFWs stated they need to be careful when involved in sexual encounters and have personal accountability for their actions to prevent AIDS, were significant findings. Both men and women were supportive of this position. It has been reported that some Latino groups tend to believe that external forces control their behavior (Caudle, 1993; Grothaus, 1996). The need to learn how to properly use a condom might reflect the desire and readiness by this population to change that attitude. This attitude may also be related to the emphasis placed on the use of preventive barriers such as condoms by outreach prevention programs in this community. The migratory patterns of MSFW might also be a determining factor in the need to emphasize the use of condoms among this population. Educational programs like condom education are very important since many MSFWs lack the knowledge and skills for proper condom use and the resources to acquire them (Marin et al, 1995). This finding is supported by Organista & Organista (1997) who found that half to two thirds of the MSFWs surveyed in Mexico were unaware of basic knowledge of male condom use.

MSFW men did not differ from women on when they should be tested for HIV/AIDS. This consensus among participants that everyone should be tested can be explained by

their knowledge about the way HIV/AIDS is transmitted. It can also be argued that MSFWs have become more aware of the risky sexual behaviors they have been engaging in and the negative consequences to their community. The sentiment among female participants was that HIV/AIDS has moved south of the border. We don't have to come north to get infected. In this study, getting tested for HIV/AIDS was considered an embarrassment. This might reflect the stigma attached to being HIV positive among Latinos. It might also explain why participants see the need to have everyone tested. These findings suggest that testing everyone lessens the stigma and the embarrassment of being singled out. This is also significant in that feeling stigmatized might not motivate a person to be tested. This attitude increases the vulnerability of exposure to the virus for this population.

The signs and symptoms of HIV/AIDS that the groups reported more frequently were related to visible physical changes that occur during the late stages of AIDS. This might be related to how AIDS is portrayed in the media. As explained before, fotonovelas and novelas (soap operas) were favorite ways of media entertainment and communication among this group. In Spanish novelas (soap operas) they see actors portraying story lines related to HIV to convey prevention messages and reach the Latino population. This is especially true with programs with migrants who are in need of health education that addresses the low literacy level found in some groups (De León-Siantz, 1994).

Most MSFWs reported not knowing someone with AIDS. Having someone who has HIV/AIDS talk to MSFW may reflect their need to bring AIDS closer to home for the purpose of making the experience less esoteric. Educational outreach, using personal testimonials from Mexicans with HIV/AIDS, has been shown to predict carrying and using condoms with occasional sex partners in Mexican migrants (Organista, Organista, Garcia de Alba & Castillo Moran, 1997).

In this study, MSFWs wanted information about AIDS that include primary and secondary prevention. This finding may reflect that migrants are recognizing their misconceptions about HIV/AIDS and the need to do something to protect themselves. This finding is supported by Shain et al. (1999), who used a behavioral intervention targeted to Latina women, were successful in decreasing the rate of reproductive health infection in women at risk for sexually transmitted diseases. Similar models have been used to address the problems of HIV prevention and empower ethnic minority groups including Latinos (Amaro, 1995; Jemmott, Jemmott & Fong, 1992). Other findings that should be considered in developing intervention programs are the fear and lack of trust of MSFWs related to their undocumented status. This might reflect a concern with the threat of being deported and consequently not being able to provide for their families.

There were some differences between men and women in how they prefer to receive information about HIV/AIDS. Men endorsed activities that tended to be more general and inclusive of a greater number of people in the community. Women, on the other hand favored more personal strategies such as small, less structured discussion groups with other women (*charlas*). These findings reflect differences in learning styles that must be addressed in prevention programs for migrants. There was a strong inclination by all

participants to want a prevention educational program that includes a developmental approach. That is, participants would be able to build their knowledge and enhanced their communication and other skills in increments. In this study MSFWs strongly verbalized the need for farm owners to support an HIV prevention program at the working sites. The need to have the support and involvement of farm owners might be interpreted as a sign of being genuinely concerned for the health and well being of MSFWs. This might also imply that if prevention programs on site are important and valued by farm owners it must be important for migrants as well.

The findings of this study suggest that a cultural perspective to HIV/AIDS prevention added to our knowledge of the assets and barriers MSFWs encounter in accessing prevention education. The study sheds light on the need to give careful consideration to the health beliefs, socio-cultural values, learning styles, and capacity of migrants in Washington State to learn prevention related to HIV/AIDS behaviors. In particular, the life-styles imposed by the migratory patterns of this group and difficulties to access and utilize health preventive services point to the need for collaboration among outreach programs, local community-based programs and states within the migrant streams.

RECOMMENDATIONS

The recommendations stated below only offered as ways to improve HIV/AIDS prevention programs for migrants in Washington State.

1. Expand the outreach educational programs to include interventions to build communication skills and capacity for the purpose of prevention.
2. Consider different learning styles that are based on culture.
3. Collaborate with local farm owners in the implementation of HIV/AIDS prevention programs.
4. Provide opportunities for outreach workers to collaborate with other outreach workers throughout the Western stream states.
5. Utilize settled out, bilingual bicultural former migrant workers as natural helpers to reach this community.
6. Include this population in federal and state research initiatives related to HIV/AIDS prevention.
7. Disseminate findings to the Latino community and the health professionals that serve them.

ATTACHMENT F

Draft

Prioritized Population Needs Assessment Key Informant Interview Protocol

Washington State
HIV Prevention State Planning Group

Prioritized Population Needs Assessment
Key Informant Interview Protocol

This is a companion piece to the HIV Prevention State Planning Group's
Prioritized population Needs Assessment Guidance

This document developed for the Statewide HIV Prevention Planning Group is one of two companion pieces to the Prioritized population Needs Assessment Guidelines.

The document was drafted by Amy Manchester Harris, MPA, of the Department of Health Infectious Disease and Reproductive Health (IDRH) Assessment Unit.

For questions or technical assistance contact your regional coordinators and/or the IDRH Assessment Unit at (360) 236-3417.

TABLE OF CONTENTS

What is Prioritized Population Needs Assessment?

Prioritized Population Needs Assessment (PPNA) is the process for ***obtaining and analyzing information to determine the current status and service needs*** of a specific targeted population (e.g., MSM, MSM/IDU, IDU). This is done within a defined geographical area such as a regional planning area, county or city.

In HIV Community Planning, the PPNA is conducted to provide data on unmet needs for the gap analysis (refer to the *Washington State HIV Prevention Gap Analysis Model Guidance*), and to balance information gathered through the Epidemiological Profile, the Community Resource Inventory, and the Statewide HIV Prevention Planning Group Effective Interventions Matrix.

You may refer to the *State HIV Prevention Planning Group Prioritized Population Needs Assessment Guidance* for additional information; copies are available through your regional coordinator or from the Department of Health, HIV Prevention Unit (360) 236-3434.

What is a Key Informant Interview?

At the very heart of what it means to be human is the ability of people to symbolize their experience through language" (Seidman, 1991)

Interviewing is a basic mode of inquiry. The key informant interview is normally qualitative and is conducted with persons who are 'knowledgeable' about the HIV prevention needs of a particular population or group of people.

The foundation of respondent interviewing is to understand the experiences of other people and how their experiences have affected their lives. It is collecting people's stories that provide a context for people's behavior and when a context is provided it can lead to an understanding of people's behavior. People's meaning of an experience affects how they carry out that experience. (Seidman, 1991) Key informant interviewing is <u>not</u> conducted to test a hypotheses or get concrete answers from a population.

In HIV prevention, key informant interviews can be used to obtain good qualitative data related to a priority population's needs, service gaps, and barriers.

What is the Difference Between Qualitative and Quantitative Data?

Both examine people and events but how they are conducted and the data generated are difficult to analyze.

<u>Qualitative data</u> utilizes a process that is primarily through words and trends. It focuses on group's dynamics, meaning and context. It cannot be statistically analyzed.

<u>Quantitative data</u> is collected in a way that can be expressed in numbers and analyzed statistically. These include such things as surveys.

- **Key informant interviews:**
  - Are good qualitative measures as they provide in-depth data and allow for follow up
  - Can be used to gather information from hard-to-reach populations
  - May be effective (in large numbers) for quantitative measures
  - Results can help in identifying key questions for focus groups and surveys

- **Key informant interview limitations:**
  - Can not tell you everything about the prioritized population
  - Can be influenced by respondents who may have personal or professional bias towards certain populations, organizations, activities, services or other areas covered by the interview. Interviewing more than one representative for a community helps in obtaining more rounded information about the population (e.g., administrator and outreach worker within the same organization)
  - Can be influenced by bias from the interviewer (see *Identifying Bias* section)

Types of Interviewing

Interview structures can range from standardized close-ended questions to interviews that are free flowing and seem more like an informal, friendly conversation. There are three main types of in-depth interviewing: standardized open-ended interview, the guided interview and the informal conversational interview.

- **Standardized Open-ended Interview**
  This type of interview has a prepared set of open-ended questions that have been carefully worded and arranged to lead the respondent through a path of questions that are applied to all respondents consistently.

Advantages of Method	Disadvantage of Method
+ Consistency of data when using more than one interviewer + Consistently applied makes it easier to analyze	- Less flexible than other two methods due to structure

Guided Interview

This type of interview utilizes a basic prepared checklist to make sure that all relevant topics have been covered during the interview. The interviewer still will explore and probe related to the answers provided by the respondent that interest the interviewer.

Advantages of Method	Disadvantages of Method
+ Allows more free form discussion + Allows for more in-depth probing while keeping the interview within the scope.	- Unskilled interviewers may get too far off the topic area - Harder to analyze information

Informal Conversation Interview

This type of interview is the one closest to a free-flowing friendly conversation, where the respondent forgets that they are being interviewed. The interviewer has a framework of information that they want to collect but the way that they get there is a flow from the respondent's immediate context. This is useful for on going participant observation fieldwork.

Advantages of Method	Disadvantages of Method
+ Free flowing friendly discussion + Useful for on going participant observation fieldwork.	- Unskilled interviewers may get too far off the topic area - Harder to analyze information

Reasons People Don't Interview

The most common reasons why people do not interview as an assessment method are related to:

- Time
- Money
- Skills

It is important to remember that any type of assessment that is worth doing or will obtain useful information, regardless of the method, takes time, energy and thoughtfulness to develop, implement and analyze.

A cost planning exercise can assist with budgeting the time, staff and funding needed to do an appropriate needs assessment for your prioritized population. It is also equally important to look at the time and skills of your staff. Needs assessment projects take staff time and energy simply in establishing the process (e.g., developing the questions, methodology). Skilled staff are needed to administer the key informant interview as well.

Core Elements to Conducting Key Informant Interviews

There are three core elements to conducting key informant interviews, each requiring prior planning. A successful key informant interview is based on clear expectations for the information wanted and has been well planned.

Three core elements:

- Recruitment and Screening
- Question Development
- Data analysis

Key Informants Recruitment

Deciding who are key informants with your prioritized population is an important element in collecting useful interview data. Many times, just like developing written surveys or focus groups, people are quick to jump at developing the questions before they have defined their prioritized population and, specifically, what they want to know from them.

Step One: **Clearly define what you need to know**

It is important to clearly know the specific information you want to gather about a particular prioritized population. Why are you interviewing key informants from or who work with the prioritized population? What specific interview questions would help you understand the local prioritized population and service needs in your area? How will the information be used?

Examples:
Why are the people accessing your program not interested in the group-level intervention you offer?

In the clients' view, what are important elements to include in an HIV prevention intervention?

Step Two: **Clearly define your prioritized population**

It is important to clearly define your prioritized population, so that the correct Key informants are interviewed. The correct Key informants can provide useful and insightful information on the needs of the priority population.

Who do you need to talk to in order to gather the information needed to answer your question(s)? In marketing terms this is called segmenting.

Example:
Prioritized population: **MSM**

What are the *important similarities and differences* your MSM audience should share?

- Race/ethnicity?
- Age?
- Economic status?
- Life experiences (e.g., incarcerated, HIV+, mental illness, substance use)?
- Certain shared activities (e.g., use internet to attract sex partners)?
- Frequent similar places (e.g. bathhouse, social events, HIV prevention activities)?
- Have certain risk behaviors (anonymous sex partners)?
- Located in a particular area (Yakima Valley, 1st Ave)?
- Utilize/underutilize a particular service (counseling/testing or care services)?
- Care or service providers assisting the priority population.

Step Three: Consider the needs of your participants

To maximize your prioritized populations' participation in key informant interviews, you will need to consider their needs.

- **Confidentiality**

  If participants believe that their confidentiality will be protected they are more likely to agree to participate in a key informant interview and be more likely to openly share their opinions during the interview. See confidentiality section for information on Washington State confidentiality laws.

- **Interview Location and Time**

  It is important to interview in a comfortable and convenient place not only for the respondent but also the interviewer. The interview space needs to be safe, well lit, confidential, quite and have enough room for the interviewer to be able to record the information provided.

Step Four: Develop recruitment methodology and screening tool

Once you have decided why you want to interview, you need to agree on a blend of people that you want to interview to ensure diverse perceptions, knowledge and experiences.

If you are planning to make program improvements or funding decisions based on key informants data you need to make sure that you have the right people at the table. A well thought out recruitment plan is essential.

It is important for recruited participants to *fully understand* that they are agreeing to discuss a particular topic within an interview setting.

It is unethical to mislead or coerce key informants participation such as misrepresenting the intentions or withholding services from persons who aren't interested, do not attend or do answer every interview question.

Developing Key Informant Interview Questions

Once you have defined what information you want from your prioritized population and who they are, you are ready to move question development.

Key informant interviews are normally conducted from of a pre-determined questionnaire that also can contain a pre-determined script. Adherence to the script and to the *exact* wording of each question is important to receive unbiased data from the prioritized population being interviewed.

The interview survey normally collects basic demographics about the person being interviewed. It then asks simple non-intrusive questions first and then moves to more sensitive questions as the interview progresses. This allows the interviewer to build rapport with the respondent (persons being interviewed).

Depending on the type of data that is wanted through the key informant interviews, the questions could be open-ended, concrete questions with set responds or a blend of both. Open-ended questions can provide good information that concrete questions may not pick up, however they are qualitative data and are difficult to analyze. Most conceptualize the project by answering a series of simple questions:

- What do you want to know?
- What do you want to learn?
- What questions are you trying to answer?
- What difference will it make (yeah, so what)?
- What's the best method to get those answers (focus group, written survey, discussion group, interviewing)?

Interview Length

It is also important to look at the length of the interview, not only for the interviewer by also for the respondent. How long will it take to answer all the questions? Remember that open-ended and complex questions will take the respondent longer to answer and to record. Many respondent interviews run about 45 minutes to 1 hour. Although, depending on the information gathered, it may take longer.

Tips to Developing Better Questions

Clear Questions

"Many of the meanings which are clear to one will be relatively opaque to the other, even when the intention is genuine communication." (Cicorurel, 1964) Being able to articulate your questions in a short, clear and precise manner is helpful to obtaining clear response from respondents. The interviewer must use language that is reflective of the community being interviewed and should not include jargon. Also keep questions less than 25 words and keep the literacy level low.

- **Single Questions**
  Many times in conversation, people will weave multiple questions and present them as one. These types of questions can confuse a respondent, as they may not be sure which question to answer and therefore may select the one that they remember or want to answer. Asking short and clear questions also enables the interviewer and respondent to stay focused on the interview and saves time clarifying questions.

  Example: "Would you say you are more apt to read an article or watch a TV show about HIV prevention?"

- **Open-ended Questions**
  Questions that are truly open-ended do not have pre-determined answers and allow the respondent to respond from their own experiences.

- **Sequence the Questions**
  Most assessment gathering tools, whether it is a focus group, interview or survey all utilize a funneling approach to their questions. An interview would not start a typical interview by asking the hardest and most sensitive questions first, but would 'work up to them' by first establishing rapport and getting some basic information.

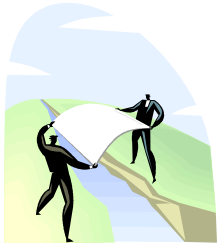
- **"Experience/Behavior" before "Opinion/Feeling" Questions**
  A context normally must be established prior to being able to get the opinion and feeling of respondents. In normal conversations, person normally provided clarifying information prior to expressing a feeling or opinion. Asking experience and/or behavior questions first enable them to go directly to talking about their opinions and feelings.

- **Asking Sensitive Questions**
  With HIV prevention target population needs assessments, the interviewer probably will need to ask sensitive questions. Although it is important to understand people's experiences and behaviors, it is also important to know when and how to ask sensitive questions so that respondents are truthful and do not terminate the interview. Clear information during the informed consent process stating that sensitive information about sex and/or needle use will be asked can also assist in preparing the respondent or allow them to decline, if they do not feel comfortable.

- **Pre-test Your Questionnaire**
  Ensure that the questionnaire can be clearly understood by the respondents. This also can assist in finding out if the questions you are asking generate the data you wanted.

Developing Questions for the Gap Analysis

PPNA in HIV prevention planning is normally conducted to collect information on the unmet needs of a prioritized population to be folded into the gap analysis.



Why is a gap analysis conducted in HIV prevention planning?
Gap analysis is conducted to identify met and unmet needs within a prioritized population. Identification of those needs assists in prioritizing prevention funds, prioritized populations to work with and interventions to be utilized. Needs assessment data helps to determine the current status of prevention needs and services.

The Washington State HIV Prevention Planning Gap Analysis Model focuses on three areas of data to assess a community's HIV prevention needs:

Knowledge

- ✓ HIV is a potential life threatening disease
- ✓ Knowledge of the behaviors that transmit HIV
- ✓ Knowledge of HIV status
- ✓ Knowledge of HIV Prevention
- ✓ Where to go for services, resources and social support
- ✓ Access to culturally and linguistically appropriate competent interventions

Attitudes and Behaviors

- ✓ Perceived susceptibility and vulnerability
- ✓ Motivation, intention, and commitment to reduce high risk behaviors and increase low risk activities
- ✓ The self-esteem and confidence that one can utilize risk reduction behaviors consistently and under a variety of circumstances
- ✓ Awareness of social influence and social norms that impact HIV transmission
- ✓ Sense of personal responsibility to not transmit HIV to others

Behavioral/Skills

- ✓ Identification of high risk behaviors and ability to assess own risk of infection
- ✓ Use of risk reduction practices
- ✓ Use of communication skills that reduce HIV transmission
- ✓ Use of problem solving and decision making skills that reduce HIV transmission
- ✓ Level of peer support for behavior change
- ✓ Level of norms regarding acceptability of insisting on safer sex
- ✓ Level of maintenance of consistent behavior change

What's an Unmet Need?

HIV prevention services for a specific prioritized population that are not currently being addressed through existing HIV prevention services/activities, either because no services are currently available or because available services are either inappropriate or inaccessible to the prioritized population.

-Washington State HIV Prevention Planning Gap Analysis model

Getting to the Unmet Need

Within each of these three focus areas and for each sub-question (listed previously), information about access and resources is assessed both to identify if there is an unmet need and to prioritize resources. Needs assessment and community resource information (CRI) data are used to complete the gap analysis grids (refer to the Attachment section for copies of the gap analysis grids).

Assessment questions gathered from the needs assessment:

- How much information does the prioritized population possess?
  E.g., knowledge of how HIV is transmitted
- How many resources, services and policies outside of your direct control affect the need?

Assessment questions gathered from the Community Resource Inventory:

- How do existing HIV resources address the prevention need?
- If funding were lost, would it impact the prevention need?

Final conclusion questions from all information gathered:

- Is the prevention need unmet?
- What is the priority of funding interventions based on the prevention need?

Once the needs assessment has been conducted and the resulting data has been folded into the gap analysis model, the gap analysis is complete. This should provide a clear picture of the HIV prevention needs (both met and unmet) in your RPG service area.

Getting help with developing the right questions for your prioritized population

Assistance in developing questions can be obtained from:

- Internal assessment or data staff within your agency, if available
- Your Regional AIDSNET office
- The Department of Health, IDRH Assessment Unit, 360-236-3417.

Remember: All questions and focus group materials should be submitted to DOH prior to being implemented.

PPNA and Human Subjects Review

Research involving human subjects sponsored by the DOH requires prior review and approval by the Washington State Institutional Review Board (WSIRB). Prioritized Population Needs Assessments are almost always non-research activities. In some cases, however, data collected for non-research purposes later may be used for research that requires IRB review.

The primary intent of the needs assessment determines whether it qualifies as research that requires review by the WSIRB.

Needs assessments are research if the:

- Primary intent is to produce generalizable knowledge to improve public health practice;
- Intended benefits of the project may or may not include study participants, but always extend beyond the study participants, usually to society; and
- Data collected exceed the requirements for care of study participants or extend beyond the scope of the activity.

Needs assessments are not research if the:

- Primary intent is to identify and control a health problem or improve a public health program or service;
- Intended benefits of the project are primarily or exclusively for the participants or the participants' community;
- Data collected are needed to assess and/or improve the program or service, the health of the participants or the participants' community; and
- Knowledge that is generated does not extend beyond the scope of the activity.

If you have questions about whether your PPNA may involve research, contact WSIRB staff at (360) 902-8075. Information about the review process is found at the WSIRB website: http://www1.dshs.wa.gov/rda/hrrs.

The Interview Format

The interview is made up of three main parts, the introduction, the interview and the conclusion. It is important to remember that an interview is a social interaction and that the respondent should be treated with respect. They are giving up their time to meet with the interviewer and are sharing their experiences or thoughts on sensitive topics.

The Introduction - Building Rapport

This is a bridging (takes people from one activity to another) activity that moves the respondent towards the questionnaire section of the interview. For interviews the rapport is established normally within the first few minutes of the interview.

All interviews should have an informed consent process many times rapport is established while going over the consent process.

- Develop trust and mutual respect
- Speak and act in ways that are non-threatening
- Cultivate a relatively neutral role but be compassionate and towards the respondent (even if you don't like him or her)
    - Techniques for establishing and maintaining trust:
        - ✓ Always be honest
        - ✓ Prove your motivation by interviewing respondents when it is best for them and not necessarily most convenient for you
        - ✓ Always keep your word and don't promise anything that you cannot keep
    - Techniques for establishing and maintaining respect and acceptance:
        - ✓ Be on time for the interview and introduce yourself
        - ✓ Dress appropriately for the person being interviewed and the setting
        - ✓ Always remain neutral
        - ✓ Be aware that the respondents are observing and questioning you too

Obtaining Informed Consent

Verbal consent **must** be obtained prior to starting any key informant interviews. Verbal consent can be documented on the consent form through an interview signed verification statement. Attached is a sample informed consent form, it is located in the Moderator Script, see *Key informant interview Tools*.

The informed consent also serves as an introduction to what will take place during the interview and provides the respondents with their rights in the process. The consent must be communicated in a manner and language that is clear and understandable and should:

- √ Remind the participant how long the interview will take (45-60 minutes).
- √ Provide an overview of the goals of the interview
- √ Remind the participant that all information is strictly confidential; the participant's name will not be used anywhere on the interview form nor reported in any form.
- √ Encourage participants to ask questions if anything is confusing or unclear.
- √ Remind participants that they can refuse to answer any questions.
- √ Address any incentives provided to the respondent (e.g., $25, movie tickets).
- √ Stress that participation is voluntary, participation does not give them an advantage and that refusal to participate involves no penalty or loss of services/care benefits. The subject may discontinue at any time
- √ Ask the participant if he/she has any questions before you begin.

Tape Recording the Interview

Recording an interview is a good way to insure that you caught every word from your respondent for transcribing. If the interviewer chooses to use a tape recorder the respondent must be given the option of being tape recorded or not. This information should be included in the informed consent and consent should be given prior to the tape recorder being used. See the Key Informant Consent example for more information.

The Interview

Successful data collection through interviewing is obtained by good conversational encounters with well-chosen respondents. To have a successful interview, interviewers need to be trained and be knowledgeable of a variety of interview techniques.

Ask all questions as they are written

The survey instrument's questions have been carefully drafted and sequenced so that the right information is being obtained from all respondents in the same way.

It is important to ask all the questions as they are written to make sure that the information you gather for all the respondents is based on the same questions asked. Changing small words or reversing the order of the questions can change the meaning of the questions.

Examples:
Is there a supervisor who oversees the trainings on-site?
Is there someone in charge at the trainings?

These two questions could generate very different response from the respondent being interviewed which would change the information being collected.

Record All Answers Exactly as Stated

It is important to capture the respondent's responds in their own words. Try not to paraphrase, re-phrase or suggest answers.

- Ask for clarity if anything is confusing. If something is not clear, ask for clarification. It is better to get clear information than assume what you heard.
- Review all open-ended responses to ensure that you are recording what they are intending.
- Do not make assumptions about medical conditions. Clarify medical statements that are not clear.

  Example: "I get a rash between my legs" does not necessarily mean they have a sexually transmitted disease.

- **Probe and Follow-up Questions**
  Probing is done to deepen the response to a question and to increase the richness of the data being obtained. It also cues to the respondent to the level of response(s) that are desired during the interview.

  Ways to probe:

  - Restate the question**.** If respondent gives a vague answer it may be appropriate to re-read the questions again.

  - Be silent. This can let the respondent have a chance to think about their answer and let them know the interviewer is willing to wait for their response.

  - Ask additional questions. If their answer is still vague after re-stating the question, the interviewer may want ask:
    Could you say something more about that?
    Can you give a more detailed description of what happened?

- **Interpret Questions**
  During interviews the respondent may make statements that need to be interpreted so that they are not misinterpreted by the interviewer. Asking follow up questions that are paraphrasing a response may assist in limiting misinterpretation (e.g., so, would you say you are …fearful, confused…?).

- **Free Flow Conversation and Maintaining Control**
  This is the sometimes the most difficult balance to strike. If the interview is too structured then the persons may not feel welcome to provide in-depth information about the topics of inquiry. However, the interviewer must also be able to get the information they need without having the respondent take control of the interview. The interviewer must remember why they are interviewing the respondent and the goal of the needs assessment process.

Identifying Bias

This section adapted from the work of Professor C. George Boeree of Shippensburg University on Qualitative Research Methods.

An interviewer may have strong opinions or feelings related to the topics that are being addressed in the survey or focus group they are conducting. It is however, important to not let those biases affect collecting data from the respondent(s). The information you want to receive from the respondent is one their own feelings or experience and not a reflection of what they think you want to hear.

Bias, is a human characteristic found in all people. Bias can be related to a number of core characteristics of a person such as a person's:

- Gender
- Age
- Sexual orientation
- Ethnic or national identification
- Religion or philosophy of life
- Political party or orientation
- Family up bringing

How Does One Minimize Bias?

To assist with minimizing bias it is helpful if the interviewer becomes aware of their own biases. What issues or answers hit your "hot buttons"? Is it the person who is engaging in high-risk activities and isn't caring for themselves or others around them? Or, is it the person who believes that all persons with HIV/AIDS should be quarantined?

HIV is a disease that affects people in many different ways and touches many of our societies' issues around sexuality and/or drug use. The interviewer may be asking sensitive questions and their role is to be the reporter and record the respondent's truths and perspectives on the question.

Interviewer vs. Outreach worker/Educator

Many of the people working in the field of HIV/AIDS come to it because they want to help reduce HIV infection. With that comes a deep dedication to the field of HIV prevention and the desire to share important prevention messages with anyone at risk for HIV. The challenge for the outreach worker or educator who is also being a needs assessment interviewer is to separate the two roles. To obtain good quality data it is important to only do one task at a time. Questions from the respondent or requests about specific referral information should be held until after the interview.

Collecting and Analyzing the Data

It is important to consider how the data will be collected and analyzed during the PPNA key informant interview planning process prior to the implementation of the interviews.

Questions to ask prior to starting your interviews:

- How will the data be utilized?
- Who will be responsible for collecting the data?
- Will the data be collected in a uniform manner?
- How will the data be analyzed?
- Where will the data be housed?

If you have people within your agency for data analysis, it may be useful to get their help in the planning stages of your needs assessment. They also may be able to assist in making sure the data collected will actually answer the questions you have for the target population(s).

Analyzing the Data
Analyzing qualitative data can be tricky. If you have not done this kind of analysis it is recommended that you seek assistance.

Points to remember when analyzing key informants data

- Look for the big ideas – trends or patterns in the information provided
- Look for commonalities and differences
- Consider the words, context which the words were stated in and specificity of the information provided
- Don't take a comment at face value – remember the context
- It is important to remember:
  - What was said
  - Who said it
  - How much was said about a specific issue
  - The order that things were said and,
  - The way things were said.

Ensuring Confidentiality

Data Collected
Any information collected during the PPNA process that personally identifies an individual (e.g., name, address etc.) is confidential information. It is best to use a system for separating data from the individual's demographic and locating information.

Eliminate any references to specific individuals in the transcripts (e.g., Dr. Smith to "my doctor").

Discussion of Data
Any discussion of data should not include use of specific participant's name or other information that may lead to identification of the participant. Some agencies also have their employees or the persons working on the needs assessments sign a confidentiality statement stating that they will not discuss information gathered.

Data Storage
After completion of the PPNA, all data collected (surveys, notes, cassette tapes etc) should be kept in a locked file cabinet. Only staff involved in the process should have access to the information. Once the data has been summarized and reported, source materials should be destroyed.

Every individual with access to confidential information must take personal responsibility for its protection. Community planning activities that collect information are bound by Washington State's confidentiality laws (RCW 70.24.105).

Violation of any provision is a gross misdemeanor punishable by imprisonment for up to one year. **In addition, violation may result in civil liability of up to $10,000 for reckless or intentional breech.**

Resources/References

Much of the material used for this section of the prioritized population needs assessment guidance was adapted from:

Assessing the Need for HIV Prevention Services:
A Guide for Community Planning Groups

Academy for Educational Development's Center for Community-Based Health Strategies. (202)884-8000

Single copies of this publication are available from the National AIDS Clearinghouse at no cost. Additionally, the AIDSNET Coordinators will have copies of this document.

Good Questions Better Answers:
A Formative Research Handbook for California HIV Prevention Programs

California Department of Health Services Northern California Grantmakers AIDS Task Force. For copies call California AIDS Clearinghouse at (213) 845-4180.

Seidman, I.E. Interviewing as qualitative research: a guide for researchers in education and the social sciences (1991). New York: Teachers College Press.

Cicorurel, A.V. Method and measurement in sociology (1964). New York: Free Press of Glencoe.

Boeree C.G. The Qualitative Methods Workbook. Shippensburg University. (an "e-text" prepared for the college course Qualitative Research Methods). Located at: *http://www.ship.edu/~cgboeree/qualmeth.html*.

Taylor-Powell. E. Questionnaire Design: Asking questions with a purpose. (1998) University of Wisconsin-Extension.

Natter, Jeff. Interviewing Tips. (2000). Public Health - Seattle and King County.

In addition, assistance/guidance/information may be available from: Statewide Planning Group members, AIDSNET Coordinators, Department of Health staff, and/or staff at local health departments and community-based organizations.

Key Informant Tools

---------- KEY INFORMANT *CONSENT FORM EXAMPLE*----------

Introduction and Purpose
Region X AIDSNET is an organization that is responsible for overseeing how HIV prevention efforts are done in this area. We work in connection with the local health departments and AIDS community based organizations for the XX counties that are in Washington State. As part of the Regional HIV Prevention yearly planning process we are assessing HIV prevention needs of prioritized population X in Region X. Information from this interview will help us better serve prioritized population X in Region X.

Procedures
Today, if you choose to, you will participate in a key informant interview with *Fanny Friendly*, the Region X AIDSNET Coordinator. Your will be asked about the perceived and actual barriers faced by prioritized population X in Region X, the state of HIV Prevention efforts in your area, and the identification of service gaps that need to be filed for prioritized population X to be more successful in preventing HIV infection. The interview will take about 30 to 60 minutes of your time.

In order to make sure that we capture all of your concerns/opinions about HIV prevention needs of prioritized population X, we would like to tape record this session. No identifying information about you will be included in the transcription. Only those working with the project will have access to the tape. All tapes will be deleted once they have been transcribed. The transcripts will be kept in a secure file and only those directly related to the study will have access to them.

Risk, Stress and Discomfort
A member of the Region X AIDSNET staff is conducting today's interview. Some of the questions we will be asking will be about how your programs work, the experiences the program has had reaching the priority population X and what improvements you would like to see to help serve the priority population better. Participation is voluntary; you can pass on any of the interviews question for any reason. Just let me know that you want to pass on the question. Information gained form this needs assessment will not directly affect your program or the funding of any particular HIV prevention program. You may stop the interview at any time if you feel uncomfortable.

Confidentiality
To keep your identity private, we will not use your real names during the interview. When we transcribe the interview information we will strip away all identifying information including agency location and name. After the interview is transcribed, the tape will be erased. The transcripts will be kept in a secure file and only those directly related to the study will have access to them.

Other Information
The information you share with us today will be reviewed and compared to the responses gained from other health workers like you in the region. We will be looking for similarities and differences between the needs and situations that exist in various parts of our region. The final report will be composed and given to the Region X HIV Prevention Planning Committee as a tool to help guide the planning process for the upcoming year.

Contacts
If you have any questions about this study, please contact *Fanny Friendly,* Region X AIDSNET at XXX-XXX-XXXX or XXXXX@someagency.com . If you have questions about your rights, as a participant in this needs assessment, you may call Maggie Frederick at 800-583-8488. She works for and with the Human Research Review Board. The review board works to protect the rights of all people who participate in research. You don't have to give your name if you call.

Consent
If you didn't understand any part of what I just told you, be sure to ask questions before you agree to participate.

Do you have any questions?

Are you willing to be in the study?

Are you willing to be tape-recorded?

To protect your privacy, we are not asking you to sign the consent form. The witness and I will sign this form now indicating that I have informed you of your rights as a subject in this study.

_____ _____
Interviewer's Signature Date

(Turn on Recorder, if consented to be tape-recorded)

The recorder has been turned on and we are ready to start our interview. For the purposes of this record would you please confirm that I have read the informed consent document, we have discussed any concerns or questions you have on the consent and you have given consent to be interviewed. Thank you. We will now start the interview.

CC: Study participant, if wanted
Needs Assessment files

Suggested Collected Respondent Demographics

This type of data may be put at the beginning of the respondent survey to collect some background information about the respondent.

Ethnicity

Do you consider yourself Hispanic or Latino/a?

☐ Yes ☐ No

If yes, are you:
(Please circle only one response)

1. Puerto Rican
2. Mexican-American
3. American-Chicano
4. Mexican
5. Cuban
6. Central/South American
7. Dominican Republican
8. Other? (Please specify) _____

Gender/Age/Race

(Please place a check mark in the box that best describes you)

(M=males; F=females; T=transgender)	**≤ 19 years old**			**20-29 years old**			**30+ years old**		
	M	F	T	M	F	T	M	F	T
American/Indian/Alaska Native									
Asian									
Black or African American									
Native Hawaiian or Other Pacific Islander									
White									
More Than One Race									
TOTAL									

Education *(may or may not be important for your prioritized population)*

In school, what is the highest grade you ever completed?
(Please circle only one response.)

1. Less than high school
2. High school graduate (including G.E.D)

3. Some College
4. College graduate
5. Post-graduate

County of Current Residence:

☐ Adams	☐ Douglas	☐ King	☐ Pacific	☐ Stevens
☐ Asotin	☐ Ferry	☐ Kitsap	☐ Pend Oreille	☐ Thurston
☐ Benton	☐ Franklin	☐ Kittitas	☐ Pierce	☐ Wahkiakum
☐ Chelan	☐ Garfield	☐ Klickitat	☐ San Juan	☐ Walla Walla
☐ Clallam	☐ Grant	☐ Lewis	☐ Snohomish	☐ Whatcom
☐ Clark	☐ Grays Harbor	☐ Lincoln	☐ Skagit	☐ Whitman
☐ Columbia	☐ Island	☐ Mason	☐ Skamania	☐ Yakima
☐ Cowlitz	☐ Jefferson	☐ Okanogan	☐ Spokane	☐ Don’t Know

ATTACHMENTS

Except from the *Washington State HIV Prevention Planning Gap Analysis Model*

Note: This is only one page from the MSM Gap Analysis section.

To get a copy of the complete Gap Analysis Document, please contract the
Washington State Department of Health, Infectious Disease and Reproductive Health Assessment Unit,
360-236-3417.

Washington State HIV Prevention Planning Gap Analysis Model

Example Tables

PREVENTION NEEDS TABLE

Target Population: *MSM*

Prevention Need: *Knowledge*

		Worksheet A)	(Worksheet B			
Prevention Need Knowledge (MSM)	**How much of the target population possesses this information?**	**How do resources, services and policies outside of your direct control affect this need?**	**How do existing HIV resources currently address this need?**	**How would funding loss impact on this prevention need?**	**Is this an unmet need?**	**What is the priority of funding interventions based on this prevention need?**
1. HIV is a potentially life threatening disease	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical
Brief comments						
2. Knowledge of the behaviors that transmit HIV*	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical
Brief comments						
3. Knowledge of HIV status	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical
Brief comments						
4. Knowledge of HIV prevention**	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical
Brief comments						

ATTACHMENT G

2003 Epidemiologic Profile

DRAFT
WASHINGTON STATE EPIDEMIOLOGIC PROFILE (2003)

WASHINGTON STATE

Washington State is number XX in total population, 19th in cases of AIDS, and XXth in the level of CDC funding. The first case of AIDS was reported in 1982 and there were 10,490 cases diagnosed through the end of 2002 (and reported as of 6/30/03). The general demographics of Washington are as follows:

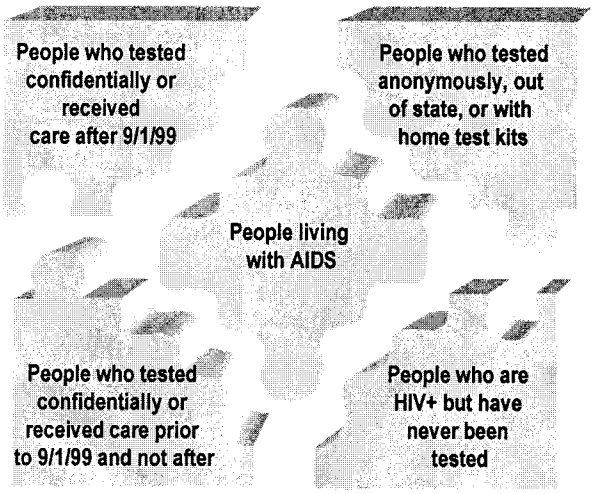
Table 1. Characteristics of the Washington State population, 1990 and 2000

	1990 Census	2000 Census	
Total population, Washington State	4,866,692	5,894,121	
Gender			
Female	2,452,945 (50%)	2,959,821 (50%)	
Male	2,413,747 (50%)	2,934,300 (50%)	
Race/Ethnicity		**Alone**	**Alone or in combo**
White	4,411,525(91%)	4,821,823 (82%)	5,003,180 (85%)
Black	152,530 (3%)	190,267 (3%)	238,398 (4%)
Asian/Pacific Islander	215,411 (4%)	346,288 (6%)	438,502 (7%)
American Indian/Alaska Native	87,226 (2%)	93,301 (2%)	158,940 (3%)
Other	-	228,923 (4%)	287,400 (5%)
More than one race	-	213,519 (4%)	-
Hispanic ethnicity (any race)	214,489 (4%)	441,509 (8%)	
Age			
<=14	1,079,962 (22%)	1,255,051 (21%)	
15-19	325,081 (7%)	427,968 (7%)	
20-24	353,638 (7%)	390,185 (7%)	
25-29	411,518 (8%)	403,652 (7%)	
30-39	868,361 (18%)	921,428 (16%)	
40-49	657,140 (14%)	945,360 (16%)	
50+	1,170,992 (24%)	1,550,477 (26%)	

HIV data

HIV data for cases diagnosed through the end of 2002 and reported as of 6/30/03 describe asymptomatic HIV cases reported as a result of the new reporting requirement as well as symptomatic cases, which have been reportable since 1987. All people living with HIV infection will fall into one of the five categories indicated in Figure 2.

Figure 2. People living with HIV infection

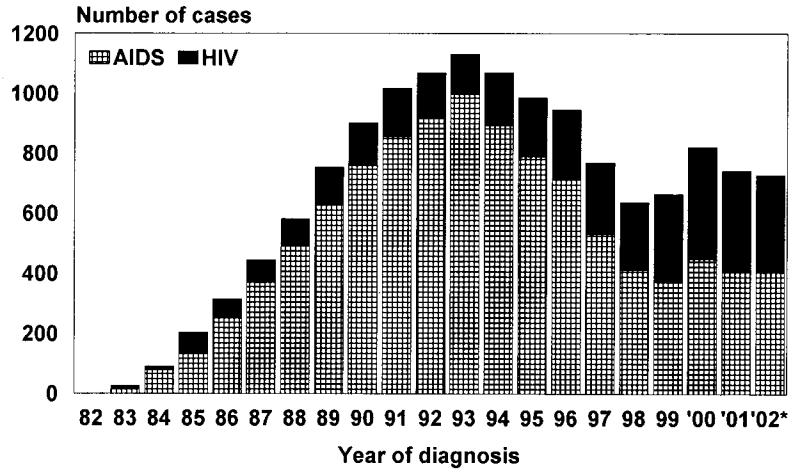


Before considering the HIV data, it is important to understand both their strengths and limitations. HIV data generated by HIV infection reporting:

- Provide a *minimum estimate* of the number of HIV + persons
- Describe those who are at an earlier point in their infection
- Do *not* effectively describe those who are newly infected (that is, do not give incidence information). The reporting system gathers data at whatever point in the infection the person chooses to get tested, rather than the time of infection. Data represent infections from weeks to years old.
- Are not representative of all HIV-infected individuals. As can be seen in **Figure 2**, the universe of HIV-infected individuals is made up of a number of different groups, and information is available for some groups through the reporting system and not for others. For instance, for those who are HIV infected and have an AIDS diagnosis, information has been found to be >90% complete. For those who have been tested confidentially or received care after 9/1/99, when reporting went into effect, data are now available but still considered to be incomplete; however, the reporting system has had several years to mature and many prevalent cases have been reported. There are people who know their HIV status because they tested anonymously, in another state, or with a test kit, and their information is not included in the reported statistics. There are people who know their HIV status because they tested or received care prior to 9/1/99 but not after, and their information is not available in the reporting system. Finally, there are those who have never been tested and are HIV-infected but do not know their status.

Figure 3 shows, with the black sections of the bars, the number of HIV cases diagnosed every year. HIV data from each region and county indicate that HIV cases have been reported in all counties except Ferry, Garfield, Lincoln, and Skamania.

Figure 3. HIV cases and AIDS cases by year of diagnosis, Washington State, 1982-2002 (Note: Cases reported as of 6/30/03; reporting for 2002 is still not considered to be complete.)



Trends in AIDS cases and deaths

Starting in the mid-1990s, the number of reported AIDS cases and AIDS deaths decreased dramatically, due in large part to the use of HAART to treat disease. In the late 1990s, trends in disease and death leveled off, as can be seen in Figure 4. This trend could be due to several factors, including treatment failure, difficulty in adhering to treatment regimens and late diagnoses delaying treatment initiation.

Figure 4. AIDS cases by year of diagnosis and AIDS deaths, Washington State 1982-2002 (Note: Cases reported as of 6/30/03; reporting for 2002 is still not considered to be complete.)

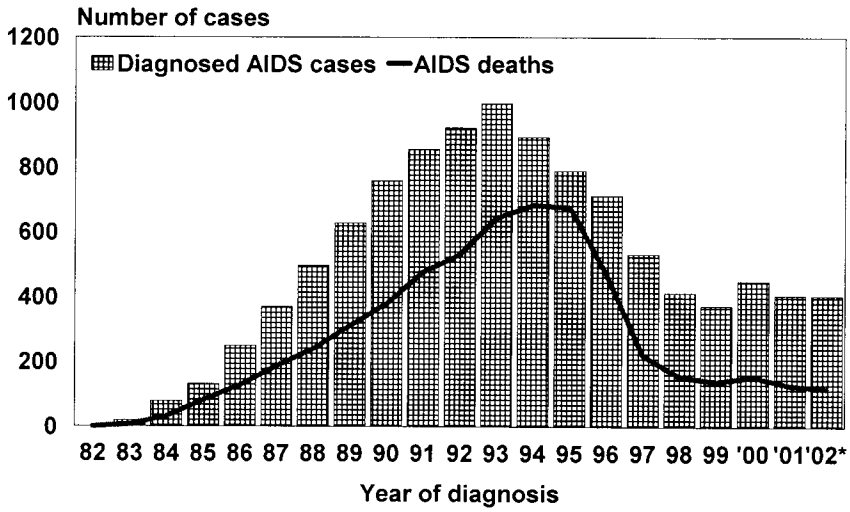


Table 11 describes those who were diagnosed with AIDS at different times in the epidemic. By comparing those diagnosed early in the epidemic with those recently diagnosed, it is possible to describe the changing demographic characteristics and risk profiles of those who are developing AIDS. Over time, increasing proportions of those diagnosed with AIDS had a residence of diagnosis outside of Region 4 (Seattle-King County), were women, and were Black or Hispanic. An increasing proportion of those diagnosed with AIDS were infected with HIV through injection drug use or heterosexual transmission. Additionally, an increasing proportion of cases more recently diagnosed are over the age of 40. This may due in part to the ability of HAART medications to delay an AIDS diagnosis in those who are HIV-infected.

Table 11. AIDS case trends over three time periods, Washington State

	Year of diagnosis			
	1982-1989 n = 1978	**1990-1997 n = 6465**	**1998-2002* n = 2047**	**Cumulative** N = 10,490**
AIDSNET region				
Region 1	80 (4%)	368 (6%)	136 (7%)	584 (6%)
Region 2	49 (2%)	203 (3%)	87 (4%)	339 (3%)
Region 3	113 (6%)	534 (8%)	175 (9%)	822 (8%)
Region 4	1452 (73%)	4116 (64%)	1171 (57%)	6739 (64%)
Region 5	173 (9%)	676 (10%)	278 (14%)	1127 (11%)
Region 6	111 (6%)	568 (9%)	200 (10%)	879 (8%)
Gender				
Male	1914 (97%)	5952 (92%)	1772 (87%)	9638 (92%)
Female	64 (3%)	513 (8%)	275 (13%)	852 (8%)
Mode of exposure				
MSM	1521 (77%)	4402 (68%)	1151 (56%)	7074 (67%)
IDU	85 (4%)	610 (9%)	253 (12%)	948 (9%)
MSM/IDU	236 (12%)	641 (10%)	176 (9%)	1053 (10%)
Heterosexual contact***	29 (1%)	385 (6%)	234 (11%)	648 (6%)
Receipt of blood products	77 (4%)	119 (3%)	15 (1%)	211 (2%)
Mother at risk for HIV	8 (<1%)	18 (<1%)	2 (<1%)	28 (<1%)
No identified risk/other	22 (1%)	290 (4%)	216 (11%)	528 (5%)
Race/Ethnicity				
White	1734 (88%)	5139 (79%)	1377 (67%)	8250 (77%)
Black	131 (7%)	641 (10%)	344 (17%)	1116 (11%)
Hispanic	78 (4%)	434 (7%)	219 (11%)	731 (7%)
Asian/Pacific Islander	19 (1%)	110 (2%)	45 (2%)	174 (2%)
American Indian/Alaska Native	16 (1%)	124 (2%)	50 (2%)	190 (2%)
Multi-race	0 (0%)	13 (<1%)	2 (<1%)	15 (<1%)
Unknown	0 (0%)	4 (<1%)	10 (<1%)	14 (<1%)
Age				
<13	12 (1%)	18 (<1%)	2 (<1%)	32 (<1%)
13-19	12 (1%)	20 (<1%)	7 (<1%)	39 (<1%)
20-29	396 (20%)	1166 (18%)	248 (12%)	1810 (17%)
30-39	939 (47%)	3039 (47%)	920 (45%)	4898 (47%)
40-49	422 (21%)	1641 (25%)	607 (30%)	2670 (25%)
50+	197 (10%)	581 (9%)	263 (13%)	1041 (10%)

*Case reporting for 2002 is not considered to be complete.

** For cases diagnosed through 12/31/02 and reported through 6/30/03.

***Those classified as heterosexual contact cases have had heterosexual sex with someone known to be at risk for HIV infection or known to be HIV infected.

HIV and AIDS in WA State

Tables 12, 13 and 14 (next three pages) summarize the most recent epidemiologic data for people diagnosed with HIV, people living with AIDS, and cumulative AIDS cases. These data establish a picture of the epidemic changing slightly. Table 12 focuses on those diagnosed with HIV (not AIDS) in Washington State by AIDSNet region, and Table 13 focuses on those living with HIV. Prior to HIV reporting, data describing those living with AIDS were used to describe those more recently infected. HIV data are now used to describe those more recently infected. In regards to gender, a higher proportion of HIV cases are in women (15%) as compared to cases in those living with AIDS (11%). The racial/ethnic distribution looks similar between those with HIV and those living with AIDS, as does the distribution by mode of exposure. In regards to age distribution, a higher proportion of HIV cases were younger at time of diagnosis, primarily because they were caught earlier in the course of their infection.

Table 14 describes those living with both HIV and AIDS and these data are useful for describing individuals in need of prevention and care services. Table 15 describes the difference in demographic and risk characteristics between cumulative AIDS cases and those living with AIDS. These data demonstrate some shifts in the epidemic. A higher proportion of those living with AIDS are female, Black or Hispanic, and infected through heterosexual contact than cumulative AIDS cases. Additionally, a higher proportion of cases in those living with AIDS have no identified risk; this is because investigations are still being conducted on their risk exposures.

Table 12. HIV cases (not AIDS) in Washington State (Cases diagnosed as of 12/31/02 and reported as of 6/30/03; reporting for 2002 is not considered to be complete*).

	WA State N = 3,427	Region 1 N = 150	Region 2 N = 108	Region 3 N = 265	Region 4 N = 2,278	Region 5 N = 372	Region 6 N = 254
Year of diagnosis							
1982-89	443 (13%)	22 (15%)	11 (10%)	34 (13%)	309 (14%)	40 (11%)	27 (11%)
1990-97	1,433 (42%)	59 (39%)	40 (37%)	127 (48%)	914 (40%)	170 (46%)	123 (48%)
98	225 (7%)	10 (7%)	7 (6%)	14 (5%)	171 (8%)	12 (3%)	11 (4%)
99	292 (9%)	8 (5%)	13 (12%)	25 (9%)	186 (8%)	36 (10%)	24 (9%)
00	373 (11%)	18 (12%)	11 (10%)	21 (8%)	258 (11%)	49 (13%)	16 (6%)
01	337 (10%)	17 (11%)	10 (9%)	24 (9%)	227 (10%)	30 (8%)	29 (11%)
02*	324 (9%)	16 (11%)	16 (15%)	20 (8%)	213 (9%)	35 (9%)	24 (9%)
Gender							
Male	2,917 (85%)	122 (81%)	77 (71%)	214 (81%)	2,034 (89%)	273 (73%)	197 (78%)
Female	510 (15%)	28 (19%)	31 (29%)	51 (19%)	244 (11%)	99 (27%)	57 (22%)
Race/Ethnicity							
White	2,543 (74%)	125 (83%)	67 (62%)	212 (80%)	1,677 (74%)	243 (65%)	210 (83%)
Black	475 (14%)	11 (7%)	7 (6%)	22 (8%)	344 (15%)	76 (20%)	15 (6%)
Hispanic	260 (8%)	7 (5%)	32 (30%)	15 (6%)	159 (7%)	34 (9%)	13 (5%)
Asian/Pacific Is.	79 (2%)	1 (1%)	1 (1%)	7 (3%)	55 (2%)	11 (3%)	4 (2%)
AmerInd/AlaskNat	50 (1%)	3 (2%)	0 (0%)	7 (3%)	29 (1%)	7 (2%)	4 (2%)
Multiracial	4 (<1%)	0 (0%)	0 (0%)	0 (0%)	4 (<1%)	0 (0%)	0 (0%)
Unknown	25 (1%)	3 (2%)	1 (2%)	2 (1%)	10 (<1%)	1 (<1%)	8 (3%)
Mode of exposure							
MSM	2,124 (62%)	66 (44%)	49 (45%)	133 (50%)	1,600 (70%)	160 (43%)	116 (46%)
IDU	356 (10%)	26 (17%)	12 (11%)	36 (14%)	146 (6%)	93 (25%)	43 (17%)
MSM/IDU	297 (9%)	17 (11%)	12 (11%)	24 (9%)	198 (9%)	31 (8%)	15 (6%)
Heterosexual	329 (10%)	18 (12%)	21 (19%)	38 (14%)	151 (7%)	55 (15%)	44 (17%)
Blood products	27 (1%)	0 (0%)	3 (3%)	1 (<1%)	17 (1%)	2 (1%)	4 (2%)
Mother with HIV	33 (1%)	3 (2%)	2 (2%)	3 (1%)	15 (1%)	6 (2%)	4 (2%)
Other/Unknown	261 (8%)	18 (12%)	9 (8%)	30 (11%)	151 (7%)	25 (7%)	28 (11%)
Age at HIV diagnosis							
<13	36 (1%)	3 (2%)	2 (2%)	4 (2%)	17 (1%)	6 (2%)	4 (2%)
13-19	90 (3%)	3 (2%)	7 (6%)	11 (4%)	49 (2%)	12 (3%)	8 (3%)
20-29	1,161 (34%)	54 (36%)	42 (39%)	79 (30%)	765 (34%)	134 (36%)	87 (34%)
30-39	1,396 (41%)	51 (34%)	39 (36%)	110 (42%)	983 (43%)	138 (37%)	75 (30%)
40-49	592 (17%)	32 (21%)	12 (11%)	47 (18%)	368 (16%)	67 (18%)	66 (26%)
50-59	152 (4%)	7 (5%)	6 (6%)	14 (5%)	96 (4%)	15 (4%)	14 (6%)

Table 13. People living with AIDS in Washington State (Cases diagnosed through 12/31/02 and reported through 6/30/03; reporting for 2002 is not considered to be complete*).

	WA State N = 4,693	Region 1 N = 272	Region 2 N = 165	Region 3 N = 390	Region 4 N = 2,909	Region 5 N = 517	Region 6 N = 440
Year of diagnosis							
1982-89	123 (3%)	7 (3%)	4 (2%)	2 (1%)	92 (3%)	10 (2%)	8 (2%)
1990-97	2,780 (59%)	152 (56%)	86 (52%)	235 (60%)	1,773 (61%)	275 (53%)	259 (59%)
98	341 (7%)	12 (4%)	16 (10%)	33 (8%)	218 (7%)	36 (7%)	26 (6%)
99	313 (7%)	24 (9%)	11 (7%)	29 (7%)	174 (6%)	47 (9%)	28 (6%)
00	385 (8%)	30 (11%)	17 (10%)	24 (6%)	222 (8%)	61 (12%)	31 (7%)
01	366 (8%)	17 (6%)	17 (10%)	27 (7%)	207 (7%)	52 (10%)	46 (10%)
02*	385 (8%)	30 (11%)	14 (8%)	40 (10%)	223 (8%)	36 (7%)	42 (10%)
Gender							
Male	4,181 (89%)	253 (93%)	139 (84%)	326 (84%)	2,677 (92%)	407 (79%)	379 (86%)
Female	512 (11%)	19 (7%)	26 (16%)	64 (16%)	232 (8%)	110 (21%)	61 (14%)
Race/Ethnicity							
White	3,440 (73%)	215 (79%)	95 (58%)	316 (81%)	2,110 (73%)	347 (67%)	357 (81%)
Black	615 (13%)	15 (6%)	5 (3%)	24 (6%)	429 (15%)	103 (20%)	39 (9%)
Hispanic	437 (9%)	21 (8%)	62 (38%)	24 (6%)	262 (9%)	41 (8%)	27 (6%)
Asian/Pacific Is.	88 (2%)	3 (1%)	1 (1%)	12 (3%)	49 (2%)	13 (3%)	10 (2%)
AmerInd/AlaskNat	98 (2%)	11 (4%)	2 (1%)	13 (3%)	54 (2%)	13 (3%)	5 (1%)
Multiracial	6 (<1%)	0 (0%)	0 (0%)	0 (0%)	5 (<1%)	0 (0%)	1 (<1%)
Unknown	9 (<1%)	7 (3%)	0 (0%)	1 (<1%)	0 (0%)	0 (0%)	1 (<1%)
Mode of exposure							
MSM	2,941 (63%)	150 (55%)	85 (52%)	209 (54%)	2,043 (70%)	232 (45%)	222 (50%)
IDU	477 (10%)	45 (17%)	17 (10%)	34 (9%)	200 (7%)	96 (19%)	85 (19%)
MSM/IDU	437 (9%)	27 (10%)	13 (8%)	33 (8%)	280 (10%)	48 (9%)	36 (8%)
Heterosexual	426 (9%)	16 (6%)	27 (16%)	60 (15%)	193 (7%)	82 (16%)	48 (11%)
Blood products	61 (1%)	5 (2%)	1 (1%)	10 (3%)	24 (1%)	12 (2%)	9 (2%)
Mother with HIV	13 (<1%)	1 (<1%)	1 (1%)	0 (0%)	6 (<1%)	4 (1%)	1 (<1%)
Other/Unknown	338 (7%)	28 (10%)	21 (13%)	44 (11%)	163 (6%)	43 (8%)	39 (9%)
Age at AIDS diagnosis							
<13	13 (<1%)	1 (<1%)	1 (1%)	0 (0%)	6 (<1%)	4 (1%)	1 (<1%)
13-19	19 (<1%)	3 (1%)	1 (1%)	2 (1%)	4 (<1%)	5 (1%)	4 (1%)
20-29	795 (17%)	45 (17%)	56 (34%)	65 (17%)	478 (16%)	85 (16%)	66 (15%)
30-39	2,241 (48%)	122 (45%)	64 (39%)	181 (46%)	1,434 (49%)	235 (45%)	205 (47%)
40-49	1,227 (26%)	71 (26%)	28 (17%)	106 (27%)	769 (26%)	133 (26%)	120 (27%)
50+	398 (9%)	30 (11%)	15 (9%)	36 (9%)	218 (7%)	55 (10%)	44 (10%)

Table 14. Demographic characteristics and risk profiles of people living with HIV/AIDS in Washington State by AIDSNet region. (Cases diagnosed through 12/31/02 and reported as of 6/30/03; reporting for 2002 is still not considered to be complete).

	Region 1 N = 414	Region 2 N = 268	Region 3 N = 645	Region 4 N = 5,127	Region 5 N = 868	Region 6 N = 685	Total N = 8,007
Gender							
Male	367 (89%)	212 (79%)	532 (82%)	4,656 (91%)	668 (77%)	569 (83%)	7,004 (87%)
Female	47 (11%)	56 (21%)	113 (18%)	471 (9%)	200 (23%)	116 (17%)	1,003 (13%)
Race/Ethnicity							
White	332 (80%)	158 (59%)	520 (81%)	3,740 (73%)	576 (66%)	558 (81%)	5,884 (73%)
Black	26 (6%)	12 (4%)	45 (7%)	763 (15%)	176 (20%)	54 (8%)	1,076 (13%)
Hispanic	28 (7%)	93 (35%)	38 (6%)	420 (8%)	72 (8%)	40 (6%)	691 (9%)
Asian/Pacific Islander	4 (1%)	2 (1%)	19 (3%)	104 (2%)	24 (3%)	14 (2%)	167 (2%)
American Indian/AlaskNat	14 (3%)	2 (1%)	20 (3%)	82 (2%)	19 (2%)	9 (1%)	146 (2%)
Multiracial	0 (0%)	0 (0%)	0 (0%)	9 (<1%)	0 (0%)	1 (<1%)	10 (<1%)
Unknown	10 (2%)	1 (<1%)	3 (<1%)	9 (<1%)	1 (<1%)	9 (1%)	33 (<1%)
Mode of HIV exposure							
MSM	210 (51%)	132 (49%)	339 (53%)	3,606 (70%)	385 (44%)	335 (49%)	5,007 (63%)
IDU	71 (17%)	28 (11%)	65 (10%)	339 (7%)	182 (21%)	126 (18%)	811 (10%)
MSM/IDU	42 (10%)	24 (9%)	57 (9%)	467 (9%)	76 (9%)	50 (7%)	716 (9%)
Heterosexual	36 (9%)	48 (18%)	97 (15%)	343 (7%)	135 (16%)	91 (13%)	750 (9%)
Receipt of blood products	5 (1%)	3 (1%)	10 (2%)	41 (<1%)	14 (2%)	13 (2%)	86 (1%)
Mother with HIV risk	4 (1%)	3 (1%)	3 (<1%)	21 (<1%)	9 (1%)	5 (<1%)	45 (<1%)
No identified risk/other	46 (11%)	30 (11%)	74 (11%)	310 (6%)	67 (8%)	65 (9%)	592 (7%)

Table 15. Comparison of cumulative AIDS cases and those living with AIDS (cases diagnosed as of 12/31/02 and reported as of 6/30/03; reporting for 2002 is not considered to be complete).

	Cumulative AIDS cases N = 10,490	% total of cumulative cases	People living with AIDS N = 4,693	% total of people living with AIDS
Gender				
Male	9,638	92%	4,181	89%
Female	852	8%	512	11%
Race/Ethnicity				
White	8,250	79%	3,440	73%
Black	1,116	11%	615	13%
Hispanic	731	7%	437	9%
Asian/PacIs	174	2%	88	2%
AmerIn/AlNat	190	2%	98	2%
Multiracial	15	<1%	6	<1%
Unknown	14	<1%	9	<1%
Mode of exposure				
MSM	7,074	67%	2,941	63%
IDU	948	9%	477	10%
MSM/IDU	1,053	10%	437	9%
Heterosexual	648	6%	426	9%
Blood products	211	2%	61	1%
Mother with HIV	28	<1%	13	<1%
No identified risk	528	5%	338	7%
Age at AIDS diagnosis				
<13	32	<1%	13	<1%
13-19	39	<1%	19	<1%
20-29	1,810	17%	795	17%
30-39	4,898	47%	2,241	48%
40-49	2,670	25%	1,227	26%
50+	1,041	10%	398	8%

Table 16 describes those who were living with both HIV and AIDS and diagnosed through the end of 2002; these individuals comprise those who are in need of both prevention and care services. For men, the primary mode of HIV exposure continues to be MSM (71%), followed by MSM/IDU (10%) and IDU (8%). For women, the primary mode of HIV exposure is heterosexual contact (48%), followed by IDU (29%). A large proportion of women (21%) have no identified risk; many of these women are presumed to have been infected through heterosexual transmission but not know of their partner's positive HIV status or risk behaviors.

Table 16. Adults and adolescents living with HIV/AIDS, by HIV exposure category and sex, Washington State. (Cases diagnosed as of 12/31/02 and reported as of 6/30/03; reporting for 2002 is not considered to be complete).

HIV Exposure Category	Males	Females	Washington Total
Men who have sex with men (MSM)	5,007 (71%)		5,007 (63%)
Female and heterosexual male injection drug users	547 (8%)	264 (29%)	811 (11%)
MSM who use injection drugs	716 (10%)		716 (9%)
Heterosexual contacts*	249 (3%)	501 (48%)	750 (9%)
Receipt of blood products	62 (1%)	23 (3%)	85 (1%)
No identified risk/other	402 (6%)	188 (21%)	590 (8%)
TOTAL	**6,983**	**976**	**7,959**

*Heterosexual contacts of a person known to have HIV or be at risk for HIV.

Tables 17A and 17B describe males (17A) and females (17B) living with HIV/AIDS by race/ethnicity and mode of HIV exposure. For men, MSM was the primary mode of exposure for men in all racial/ethnic groups. For Black, Hispanic, and American Indian/Alaska Native men, a higher proportion of cases was attributable to IDU than for white or Asian/Pacific Islander men. Men who were American Indian/Alaska Native had the highest proportion of cases attributable to MSM/IDU (29%). Black men had the highest proportion of cases due to heterosexual transmission (14%).

For women, heterosexual transmission was the primary mode of HIV exposure for all groups except American Indians/Alaska Natives, for whom 63% of cases were due to IDU. The majority of heterosexual cases were due to "sex with someone with HIV/AIDS."

Table 17A. Adults and adolescent MALES living with HIV/AIDS, by exposure category and race/ethnicity, Washington State. (Cases diagnosed as of 12/31/02 and reported as of 6/30/03; reporting for 2002 is not considered to be complete).**

HIV Exposure Category	White	Black	Hispanic	Asian/Pacific Islander	Amer.Ind. Alaska Nat.
Men who have sex with men	4,079 (76%)	373 (49%)	387 (65%)	97 (74%)	50 (49%)
Heterosexual male injection drug users	336 (6%)	122 (16%)	64 (11%)	7 (5%)	16 (16%)
MSM who use injection drugs	574 (11%)	58 (8%)	47 (8%)	4 (3%)	30 (29%)
Heterosexual contacts*	94 (2%)	110 (14%)	33 (6%)	6 (5%)	4 (4%)
Sex with IDU	*38*	*14*	*11*	*2*	*1*
Sex with blood recipient	*2*	*0*	*0*	*0*	*0*
Sex with HIV+/AIDS	*54*	*96*	*22*	*4*	*3*
Receipt of blood products	52 (1%)	1 (<1%)	7 (1%)	1 (<1%)	0 (0%)
No identified risk	212 (4%)	103 (13%)	62 (10%)	16 (12%)	2 (2%)
TOTAL	**5,347**	**767**	**600**	**131**	**102**

*Heterosexual contacts of a person known to have HIV or be at risk for HIV. **Includes 26 people of unknown race/ethnicity and 10 who identified as multiracial.

Table 17B. Adults and adolescent FEMALES living with HIV/AIDS, by exposure category and race/ethnicity, Washington State. (Cases diagnosed as of 12/31/02 and reported as of 6/30/03; reporting for 2002 is not considered to be complete).**

HIV Exposure Category	White	Black	Hispanic	Asian/Pacific Islander	Amer.Ind. Alaska Nat.
Men who have sex with men					
Female and heterosexual male injection drug users	156 (30%)	68 (23%)	11 (13%)	1 (3%)	27 (63%)
MSM who use injection drugs					
Heterosexual contacts*	268 (52%)	144 (49%)	57 (67%)	15 (47%)	13 (30%)
Sex with bisexual male	*31*	*8*	*3*	*0*	*1*
Sex with IDU	*95*	*34*	*11*	*0*	*8*
Sex with blood recipient	*8*	*2*	*0*	*1*	*0*
Sex with HIV+/AIDS	*134*	*100*	*43*	*14*	*4*
Receipt of blood products	10 (2%)	9 (3%)	1 (1%)	3 (9%)	0 (0%)
No identified risk	84 (16%)	70 (24%)	16 (19%)	13 (41%)	3 (7%)
TOTAL	**518**	**291**	**85**	**32**	**43**

*Heterosexual contacts of a person known to have HIV or be at risk for HIV. **Includes seven people of unknown race/ethnicity.

Table 18 describes newly diagnosed HIV cases in those 13-24 years of age. People in this age group are thought to have acquired their HIV infection recently since their histories of risk behaviors are probably relatively short. For people in this age group, MSM is the primary mode of HIV exposure (52%), followed by heterosexual transmission (17%) and MSM/IDU (12%). There is some regional variation; however, numbers in some regions are quite small and proportions are unstable.

Table 18. Mode of HIV exposure, by AIDSNet region, for adolescents and young adults (13-24 years) with HIV (not AIDS) (cases diagnosed through 12/31/02 and reported through 6/30/03; case reporting for 2002 is not considered to be complete).

Mode of exposure	Region 1 N = 24	Region 2 N = 26	Region 3 N = 37	Region 4 N = 325	Region 5 N = 74	Region 6 N = 45	Total N = 531
MSM	13 (54%)	10 (38%)	16 (43%)	192 (59%)	27 (36%)	18 (40%)	276 (52%)
IDU	4 (17%)	2 (8%)	1 (3%)	20 (6%)	13 (18%)	5 (11%)	45 (8%)
MSM/IDU	2 (8%)	4 (15%)	5 (14%)	35 (11%)	15 (20%)	3 (7%)	64 (12%)
Heterosex	3 (13%)	7 (27%)	11 (30%)	42 (13%)	15 (20%)	11 (24%)	89 (17%)
Blood prod	0 (0%)	0 (0%)	0 (0%)	6 (2%)	1 (1%)	3 (7%)	10 (2%)
No Id Risk	2 (8%)	3 (12%)	4 (11%)	30 (9%)	3 (4%)	5 (11%)	47 (9%)

ATTACHMENT H

Outcome Monitoring Tool

Pilot Tool

HIV Prevention Assessment

Helping us to make sure our programs are working for you.

All responses are anonymous and voluntary.

Start Here

Create your own ID code by answering a few questions that only you know the answer to.
We will ask you to create this code again on a survey at the end of the program.

ID CODE

- First letter of your mother's first name
- First letter of your mother's maiden name
- Last number of the year you were born
- First letter of the city you were born in

Your Ethnicity *Mark ☒ ONE Box*

Hispanic or Latino/a ☐ Yes ☐ No

Your Age: _____ years

Your Gender *Mark ☒ ONE Box*

- ☐ Male
- ☐ Female
- ☐ Transgender:
  - ☐ Male to female
  - ☐ Female to male

Your Race *Mark ☒ all that apply*

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Transgender:
Male to Female, Female to Male (may or may not be on hormones or have surgical gender reassignment).

1. When was the last time you were tested for HIV (the virus that causes AIDS)?

☐ I've never been tested ☐ within the last 6 months
☐ within the last year ☐ more than a year ago

2. Do you know whether or not you have HIV?

☐ Yes – I have HIV ⟶ When did you learn you were HIV positive? ____/____ (month / year)

☐ Yes — but I don't have HIV
☐ No – I don't know whether or not I have HIV ⟶ *Circle the number closest to how you feel*

	No Way		Maybe		Sure Thing
Do you **want** to get a new test for HIV?	1	2	3	4	5
If you wanted to, would you **know** where to get an HIV test?	1	2	3	4	5
Thinking about what you want and feel able to do, what are the **chances** you will get an HIV test in the next six months?	1	2	3	4	5

3. What types of partners (anal and/or vaginal) have you had sex with in the last 6 months?

Anal Sex: A penis in an anus (rectum, butt)
Vaginal Sex: A penis in a vagina

Main Sex Partner ——→ A partner who you feel committed to above anyone else

Check one:
- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ No main partner

Non-Main Partner(s) ——→ Anyone you are having sex with, who is not a main sex partner

Check all that apply:
- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ No non-main partner(s)

Main Sex Partner Questions

If you do not have a main sex partner, go to question 7.

4. Does your main sex partner...

a. have other partners?	☐ Yes	☐ No	☐ Don't Know
b. use injection drugs?	☐ Yes	☐ No	☐ Don't Know
c. have HIV/AIDS?	☐ Yes	☐ No	☐ Don't Know
d. know whether or not you have HIV/AIDS?	☐ Yes	☐ No	☐ Don't Know

5. Have you and your main sex partner talked about whether one of you has HIV?

☐ Yes → *Go to question 6.*

☐ No →

	No Way		Maybe		Sure Thing
A. Do you **want** to talk to your partner about whether either of you has HIV before the next time you have sex (anal and/or vaginal)?	1	2	3	4	5
B. If you wanted to, would you be **able** to talk with them about if either of you have HIV before the next time you have sex? *Example: know what you'd say, know your partner would be willing to talk about HIV.*	1	2	3	4	5
C. Thinking about what you want and feel able to do, what are the **chances** you will talk about whether either of you has HIV before the next time you have sex with your partner?	1	2	3	4	5

6. Now, please think about the last 4 times you had anal and/or vaginal sex with your main partner.

	Never		Half the Time		Always
How often did you use condoms?	1	2	3	4	5

	No Way		Maybe		Sure Thing
A. Do you **want** to use condoms with your main sex partner the next time you have sex (anal and/or vaginal)?	1	2	3	4	5
B. If you wanted to, would you be **able** to use condoms? *Example: know what you'd say, know how to use condoms, know your partner would be willing to use them.*	1	2	3	4	5
C. Thinking about what you want and feel able to do, what are the **chances** you will use condoms the next time you have sex with your partner?	1	2	3	4	5

Non-Main Sex Partner Questions

If you only had a main sex partner or no sex partner(s) in the last 6 months, go to question 9.

7. Do any of your non-main sex partner(s)...

a. have other partners?	☐ Yes	☐ No	☐ Don't Know
b. use injection drugs?	☐ Yes	☐ No	☐ Don't Know
c. have HIV/AIDS?	☐ Yes	☐ No	☐ Don't Know
d. know whether or not you have HIV/AIDS?	☐ Yes	☐ No	☐ Don't Know

8. Have you and all your non-main sex partner(s) talked about whether one of you has HIV?

☐ Yes → *Go to question 9.*

☐ No →

	No Way		Maybe		Sure Thing
A. Do you **want** to talk about whether you or they have HIV before the next time you have sex (anal and/or vaginal)?	1	2	3	4	5
B. If you wanted to, would you be **able** to talk with them about whether you or they have HIV before the next time you have sex? *Example: know what you'd say, know your partner would be willing to talk about HIV.*	1	2	3	4	5
C. Thinking about what you want and feel able to do, what are the **chances** you will use condoms the next time you have sex?	1	2	3	4	5

9. If you wanted to use condoms, would you be able to get them? 1 2 3 4 5

Concerning Drugs and/or Alcohol

10. In the last 6 months, did you or your partner(s) use Viagra? ☐Yes ☐No ☐Don't Know

11. In the last 6 months, did you use drugs or drink alcohol right before or during the times you had sex?

☐ No → *Skip section and go to question 13*
☐ Yes → Which substance(s) did you use before or during sex?

	Yes	No
Crack, cocaine, speed, crystal meth	☐	☐
Opiates (heroin, methadone, dilauded, percocet)	☐	☐
Poppers or party drugs (Ecstasy, Special K, GHB)	☐	☐
Alcohol	☐	☐

Other -- What? _____

12. Compared to when you don't use, do alcohol and/or drugs make you more or less likely to...

	More likely		No effect		Less likely
Use condoms for anal and/or vaginal sex?	1	2	3	4	5
Talk about whether you or your partner has HIV before you have sex?	1	2	3	4	5
Have sex with more partners?	1	2	3	4	5
Have sex you regret later on?	1	2	3	4	5

13. Concerning your use of alcohol and/or drugs...

	No Way		Maybe		Sure Thing
A. Do you **want** to stop or cut down on the amount you use?	1	2	3	4	5
B. If you wanted to stop or cut down, would you be **able** to do it?	1	2	3	4	5
C. Thinking about what you want and feel able to do, what are the **chances** you will stop or cut down on the amount you use in the next 6 months?	1	2	3	4	5

14. Alcohol and drug treatment

	No Way				Sure Thing
A. Do you **want** to get into treatment?	1	2	3	4	5
B. If you wanted to get into treatment, would you be **able** to do it?	1	2	3	4	5
C. Thinking about what you want and feel able to do, what are the **chances** you will get into treatment in the next 6 months?	1	2	3	4	5

15. In the last 6 months, have you shared needles to inject drugs, hormones, steroids, or vitamins?

☐ No → *Go to question 16*

☐ Yes

	No Way				Sure Thing
A. Do you **want** to quit sharing needles?	1	2	3	4	5
B. If you wanted to, would you be **able** to quit sharing needles (deal with the desire or pressure to share)?	1	2	3	4	5
C. Thinking about what you want and feel able to do, what are the **chances** you will not share needles the next time you inject?	1	2	3	4	5
D. If you wanted to, would you be able to get clean needles?	1	2	3	4	5

16. In the last 6 months, have you shared injection equipment (including cookers, water, cotton, frontloading and backloading)?

☐ No → *Stop here. You are done.*

☐ Yes

	No Way				Sure Thing
A. Do you **want** to quit sharing injection equipment?	1	2	3	4	5
B. If you wanted to, would you be **able** to quit sharing injection equipment? *Example: deal with the desire or pressure to share*	1	2	3	4	5
C. Thinking about what you want and feel able to do, what are the **chances** you will not share equipment the next time you inject?	1	2	3	4	5

For agency use only:

Date _____ Staff _____

Agency Name _____ Region _____

Site location _____ County _____

Intervention Name _____

Completed by Client

- ☐ Without instruction
- ☐ With individual instruction
- ☐ In a group

ATTACHMENT I

Letters of Concurrence

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

September 25, 2003

Mr. Carlos M. Smiley
Grants Management Officer
Procurement and Grants Office
Centers for Disease Control and Prevention
2920 Brandywine Road, Room 3000, Mailstop E-15
Atlanta, Georgia 30341-4146

Dear Mr. Smiley:

ATTN: Charlotte Flitcraft

RE: Program Announcement 04012 - Cooperative Agreement Number U62/CCU002018, Washington State HIV Prevention Project

On behalf of the Washington State HIV Prevention Planning Committee (SPG), we are confirming our concurrence with the Washington State Department of Health (DOH) application to the CDC for 2004 HIV prevention funds, with one reservation for subsequent funding periods. The SPG is concerned with the continued allocation of $57,000 to the University of Washington, HIV/AIDS Program Development and Evaluation Unit, to provide technical assistance to Friend to Friend programs in the state. The SPG views technical assistance as a critical element to successful implementation of many HIV prevention programs, and would like to see these funds used to provide technical assistance to more programs than just this one community-level intervention. The SPG will work with DOH in future planning cycles to ensure this priority is clearly articulated in future Comprehensive HIV Prevention Plans.

1) In August 2003, the SPG received reports from seven ad hoc regional plan review committees who had reviewed the seven regional plans to assure that each was produced according to the CDC and SPG guidance for regional HIV prevention planning. The SPG also reviewed, and voted to accept, a final draft of its 2004 HIV Prevention Plan Update, which reflected the priorities and processes identified in the regional plans.

2) DOH ensured that the SPG had sufficient time to review the application by distributing copies of the application to all members, by overnight delivery, one week prior to the SPG meeting of September 25, 2003. At this meeting, the SPG scheduled 80 minutes on the agenda to fully review and discuss the application prior to a vote on consensus.

Despite our reservation about the application, we feel proud of how the SPG and DOH have worked together to accomplish so much with such a diverse group of individuals. This was reflected in the SPG's review of DOH's application for HIV prevention funds.

Jim Minahan
Community Co-Chair
Washington State
HIV Prevention Planning Group

Jack Jourden
Department of Health Co-Chair
Washington State
HIV Prevention Planning Group

cc: Stacy Bourgeois

SPOKANE REGIONAL HEALTH DISTRICT

1101 West College Avenue
Spokane, WA 99201-2095

509.324.1500 | TEL
509.324.1464 | TDD
www.SRHD.org

June 4, 2003

Jack Jourden
Washington State Department of Health
PO Box 47844
Olympia WA 98504-7844

RE: 2004 Region I AIDSNET Letter of Concurrence

Dear Jack:

Please be advised that the Region I AIDSNET Planning Group has reviewed the proposed allocation of funds (federal, state, and other) for HIV prevention services in the region. After reviewing all funding sources and populations targeted, we find that the proposed allocations meet the identified needs and 100% of CDC funds are targeting the prioritized prevention needs identified by the Regional Planning Group and stated in the Region 2004 Prevention Plan with HIV+ persons being the top priority.

Sincerely,

Dale Briese
Community Co-chair

Barry Hilt
Health District Co-chair

CONCURRENCE

Yakima Health District
104 North First Street
Yakima, Washington 98901
Phone (509) 575-4040
Fax (509) 575-7894

June 30, 2003

Jack Jourden, Director
Washington State Department of Health
Infectious Disease and Reproductive Health
P.O. Box 47844
Olympia, WA 98504-7844

Dear Jack:

Please be advised that the Region II Planning Council has reviewed the proposed allocation of funds for HIV prevention services in the region. We find that the proposed allocations meet the criteria of utilizing 100% of the Centers for Disease Control and Prevention and 50% of the Omnibus (state) funding to target the prioritized populations and effective interventions, as outlined in the Region II 2004 HIV Prevention Plan.

Sincerely,

Deborah Severtson-Coffin

Community Co-chair
Deborah Severtson-Coffin

Health Dept. Co-chair
Wendy Doescher, Region II
AIDSNET Coordinator

SNOHOMISH HEALTH DISTRICT

REGION 3 AIDS SERVICE NETWORK
3020 Rucker Avenue, Suite 208
Everett, WA 98201-3900
425.339.5211 FAX: 425.339.5253

Healthy Lifestyles, Healthy Communities

July 15, 2003

Jack Jourden, Director
Washington State Department of Health
Infectious Disease and Reproductive Health
P.O. Box 47844
Olympia, WA 98504-7844

Dear Jack:

Please be advised that the Region 3 HIV/AIDS Community Planning Group met on Wednesday, June 11, 2003 and reviewed the currently proposed allocation of funds for HIV prevention services in the region for next year. We find that the proposed allocations meet the criteria of utilizing 100% of the Centers for Disease Control and Prevention and 50% of the Omnibus (state) funding to target the prioritized populations and effective interventions, as outlined in the Region 3 2003-2005 HIV Comprehensive Prevention Plan –Year TWO.

Sincerely,

Rickey Burchyett
Community Co-chair

M. Ward Hinds, MD, MPH
Public Health Co-chair

RB/MWH:apw

Attachment 13

SEATTLE HIV/AIDS PLANNING COUNCIL

c/o Public Health – Seattle & King County
400 Yesler Way, Third Floor, Seattle, Washington 98104
Phone (206) 296-4527 Fax (206) 205-5281

July 11, 2003

Jack Jourden, Director
Infectious Disease and Reproductive Health
Washington State Department of Health
P.O. Box 47844
Olympia, Washington 98504-7844

Dear Jack:

The Seattle HIV/AIDS Planning Council is the community planning body charged with determining the priorities which dictate the expenditure of certain local, state and federal HIV/AIDS care and prevention services funds granted to Public Health – Seattle & King County. The Council serves as the Region IV Prevention Planning Group

The Council has reviewed the proposed allocation of funds for HIV prevention services in the Region. We find that the proposed allocations meet the criteria of utilizing 100% of the Centers for Disease Control and Prevention and at least 50% of the Omnibus (state) funding to target prioritized populations and support effective interventions, as outlined in the Region IV 2004 HIV Prevention Plan.

Please contact Karen Hartfield, HIV Prevention Planner (206-205-8056) should you have any questions about this correspondence.

Sincerely,

Sam Soriano, Co-chair
Prevention Planning

Bob Wood, M.D., Co-chair
Prevention Planning

Bremerton ❖
Kitsap County
Health District

Willa A. Fisher, MD, MPH, Director
109 Austin Drive
Bremerton, WA 98312
(360) 337-5235
FAX (360) 337-5298

July 10, 2003

RECEIVED
JUL 17 2003

Jack Jourden, Director
Washington State Department of Health
Infectious Disease and Reproductive Health
P.O. Box 47844
Olympia, WA 98504-7844

Dear Jack:

Please be advised that the Region V Kitsap County HIV Prevention Planning Group has reviewed the proposed allocation of funds for HIV prevention services in the county. We find that the proposed allocations meet the criteria of utilizing 100% of the Centers for Disease Control and Prevention and 50% of the Omnibus (state) funding to target the prioritized populations and effective interventions, as outlined in the Region V Kitsap County 2003 HIV Prevention Plan.

Sincerely,

Michael Karpin
Community Co-chair

Lenore Morrey
Health District Co-chair

Cc: Region V AIDSNet Coordinator

Pierce County HIV Community Prevention Planning Group

June 16, 2003

John F. Peppert
Manager, HIV Prevention and Education Services
PO Box 47840
Olympia, WA 98504-7840

RE: 2004 Letter of Concurrence

Dear John,

On June 16, 2003, The Pierce County HIV Community Panning Group voted by consensus to concur with the budget regarding the utilization of CDC and Omnibus HIV prevention dollars, presented by Mary Saffold, Region V AIDSNet Coordinator, of the Tacoma-Pierce County Health Department.

The 2004 proposed budget addresses the planning priorities of the 2004 Pierce County HIV Community Prevention Plan.

Sincerely,

Alisa Soleberg
Community Co-Chair

Charles Fann
Health Department Co-Chair

AIDS Services Network
2000 Ft. Vancouver Way
Vancouver, WA 98663

(360) 397-8086
Fax (360) 397-8106

June 18, 2003

Jack Jourden, Director
Washington State Department of Health
Infectious Disease and Reproductive Health
P.O. Box 47844
Olympia, WA 98504-7844

Dear Mr. Jourden:

On behalf of the Region 6 HIV Prevention Planning Committee we express the Committee's concurrence with the 2004 Region 6 Comprehensive Service Plan for CDC funds. We concur that 100% of the funding will be used to address priorities established in the Region 6 AIDS Network 2002-2004 HIV Prevention Plan. We also concur with the corresponding plan for Washington State HIV/AIDS Prevention (Omnibus) funds, finding that the Region 6 plan provides that more than 51% of these funds will be spent on services targeted at high-risk populations identified by the Washington State HIV/AIDS Prevention Planning Group.

Sincerely,

Janet Johnson
Community Co-chair

David D. Heal M.S.W.
Health Department Co-chair